

Case Number:	CM13-0038685		
Date Assigned:	04/16/2014	Date of Injury:	06/03/2013
Decision Date:	06/30/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	09/30/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 59 year old male who has submitted a claim for cervical disc herniation with myelopathy, lumbar disk displacement without myelopathy, and bilateral rotator cuff sprain/strain associated with an industrial injury date of June 3, 2013. Medical records from 2013 were reviewed. The patient complained of pain at cervical spine, bilateral shoulders, and lumbar spine. It was described as pins and needles sensation, aching, and numbness. Pain was aggravated in prolonged sitting, lifting heavy items, climbing stairs, walking, and standing. Physical examination on the cervical spine revealed spasm, tenderness, painful range of motion, with positive axial compression test, and distraction test. Triceps and brachioradialis reflexes were decreased bilaterally. Objective findings of the lumbar spine revealed spasm and tenderness, with positive Kemp's test. Left Achilles reflex was decreased. Supraspinatus test and shoulder depression test were positive bilaterally. Spasm and tenderness were likewise noted at bilateral upper shoulders. Sensation was diminished at the right C6 dermatome. Treatment to date has included 19 sessions of chiropractic care, home exercise program, and medications such as topical cream, Acetaminophen, Tramadol, Cyclobenzaprine, and Etodolac. A utilization review from September 11, 2013 denied the request for six (6) conservative therapy sessions consisting of; electrical muscle stimulation to the left shoulder and lumbar spine, infrared and chiropractic manipulative therapy for the cervical and lumbar spine and myofascial release for the cervical spine, lumbar spine and left shoulder because the patient had already completed 19 sessions of chiropractic care.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

SIX (6) CONSERVATIVE THERAPY SESSIONS CONSISTING OF; ELECTRICAL MUSCLE STIMULATION TO THE LEFT SHOULDER AND LUMBAR SPINE, INFRARED AND CHIROPRACTIC MANIPULATIVE THERAPY FOR THE CERVICAL AND LUMBAR SPINE AND MYOFASCIAL RELEASE FOR THE CERVICAL SPINE, LUMBAR SPINE AND LEFT SHOULDER.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, MANUAL THERAPY & MANIPULATION, 58-60

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines §§9792.20 - 9792.26, Page(s): 57-60, 114.

Decision rationale: Page 114 of the MTUS Chronic Pain Guidelines states that electrotherapy represents the therapeutic use of electricity and is another modality that can be used in the treatment of pain. Transcutaneous electrotherapy is the most common form of electrotherapy where electrical stimulation is applied to the surface of the skin. Page 57 states that low-level laser therapy, i.e., infrared lasers, is not recommended. Pages 58-59 stated that in chiropractic care, several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment. Page 60 states that massage therapy is recommended as an option and as an adjunct to other recommended treatment such as exercise, and should be limited to no more than 4-6 visits. In this case, the patient complained of persistent pain at cervical spine, bilateral shoulders, and lumbar spine. Electrotherapy and massage therapy may be a reasonable option since the patient has an ongoing active home exercise program. However, the present request also includes chiropractic manipulation. Medical records submitted for review indicate that patient completed 19 sessions of chiropractic care. Functional improvements derived from these sessions were not documented. Continuing chiropractic care is not recommended at this time, as the patient has exceeded MTUS Chronic Pain Guidelines' recommendations. Based on the aforementioned reasons, the request for six (6) conservative therapy sessions consisting of electrical muscle stimulation to the left shoulder and lumbar spine, infrared and chiropractic manipulative therapy for the cervical and lumbar spine and myofascial release for the cervical spine, lumbar spine and left shoulder is not medically necessary and appropriate.