

Case Number:	CM13-0042593		
Date Assigned:	12/27/2013	Date of Injury:	06/17/2013
Decision Date:	05/30/2014	UR Denial Date:	10/17/2013
Priority:	Standard	Application Received:	10/30/2013

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 Physical Medicine and Rehabilitation has a subspecialty in Rehabilitation Medicine and is licensed to practice in Texas and Illinois. 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 39-year-old female who reported an injury on 06/17/2013. The mechanism of injury was not provided. The patient was noted to have pain ranging from frequent moderate to severe pain in the cervical spine, lumbar spine, right shoulder, thoracic spine, right elbow, and right hand. The patient was noted to have +3 spasms in the cervical, thoracic, lumbar, shoulder, elbows, and wrists, and hands. The axial compression test was positive bilaterally for neurologic compromise for the cervical spine, and the distraction test was positive bilaterally as well as the shoulder depression was positive on the right and the right triceps reflex was decreased. The patient's diagnoses were noted to include cervical disc herniation with myelopathy, lumbar disc displacement with myelopathy, thoracic disc displacement without myelopathy, bursitis and tendonitis of the right shoulder, partial tear of the rotator cuff tendon of the right shoulder, medial and lateral epicondylitis of the right elbow, and tendonitis/bursitis of the right hand/wrist. The request was made for physical therapy 6 visits, electrical muscle stimulation, infrared therapy, paraffin therapy, chiropractic manipulative therapy, and myofascial release.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 3X2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines states that physical medicine with passive therapy can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. Treatment is recommended with a maximum of 9 to 10 visits for myalgia and myositis and 8 to 10 visits may be warranted for treatment of neuralgia, neuritis, and radiculitis. The clinical documentation submitted for review indicated the patient had 12 sessions of physical therapy and the physician indicated that the functional improvement was shown by decreased Visual Analog Scale rating from 8.0 to 7.5 and increased range of motion for the lumbar spine flexion from 15 degrees to 25 degrees. There was tenderness to bilateral paraspinal muscles from C2 through C7, bilateral suboccipital muscles, and right upper shoulder muscles. The patient was noted to have tenderness to palpation of the bilateral thoracic paraspinal muscles from T3 through T9. It was noted that the patient had a positive Kemp's test bilaterally as well as a straight leg raise test bilaterally. The patient had a Braggard's test that was positive on the right and the Yeoman's test was positive bilaterally. The hamstring reflex was noted to be decreased as was the Achilles reflex. It is noted to be tenderness to palpation of the right upper shoulder muscles and right rotator cuff muscles. Speed's test was noted to be positive on the right as was the supraspinatus test. The patient was noted to have a positive Cozen's test on the right elbow as well as a reverse Cozen's test. Bracelet test was positive in the right wrist. There were reports of continuous pain, spasm, and weakness evidenced by her abnormal physical exam findings. However, per the submitted request, the body part was not specified. The request for physical therapy 3 times a week for 2 weeks is not medically necessary and appropriate.

ELECTRICAL MUSCLE STIMULATION TO THE CERVICAL AND LUMBAR SPINE:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NMES Page(s): 121.

Decision rationale: The California MTUS guidelines indicate that a neuromuscular electrical stimulation (NMES devices) is not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant nonadherence to guideline recommendations and the submitted request failed to include the number of sessions being requested. The request for electrical muscle stimulation to the cervical and lumbar spine is not medically necessary and appropriate.

INFRARED TO THE FULL SPINE AND RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Infrared Therapy.

Decision rationale: The Official Disability Guidelines do not recommend infrared therapy over other heat therapies. There is a lack of documentation indicating the necessity and the rationale for this therapy. Additionally, per the submitted request, there is a lack of documentation indicating the quantity of infrared being requested. The request for infrared to the full spine and right shoulder is not medically necessary and appropriate.

CHIROPRACTIC MANIPULATIVE THERAPY TO THE FULL SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The California MTUS states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement a total of up to 18 visits over 6 to 8 weeks may be appropriate. Treatment for flare-ups requires a need for re-evaluation of prior treatment success. Treatment beyond 4 to 6 visits should be documented with objective improvement in function. The clinical documentation submitted for review indicated that the patient had muscle spasms. The patient was noted to have tenderness throughout the cervical, thoracic, and lumbar spine. However, there was lack of documentation indicating the quantity of sessions being requested. The request for chiropractic manipulative therapy to the full spine is not medically necessary and appropriate.

MYOFASCIAL RELEASE TO THE RIGHT ELBOW, LUMBAR SPINE, CERVICAL SPINE, RIGHT WRIST/WRIST STRETCHES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 58-59.

Decision rationale: The California MTUS Guidelines recommend massage therapy that is limited to 4 to 6 visits in most cases. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided. This lack of

long-term benefits could be due to the short treatment period or treatments such as these do not address the underlying causes of pain. The clinical documentation submitted for review indicated the patient had tenderness and spasms. There is a lack of documentation of the quantity of myofascial release that is being requested. The request for myofascial release to the right elbow, lumbar spine, cervical spine, right wrist/wrist stretches (hold 30 seconds, 5 reps is not medically necessary and appropriate.