

<b>Case Number:</b>	CM13-0049544		
<b>Date Assigned:</b>	01/15/2014	<b>Date of Injury:</b>	10/18/2012
<b>Decision Date:</b>	05/20/2014	<b>UR Denial Date:</b>	10/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/08/2013

### 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 57 year old male who was injured on 10/18/2012 while he was bending down and felt a sharp shooting pain in his mid back and bilateral shoulders. Prior treatment history has included chiropractic care, acupuncture, Biofeedback, and exercise. Diagnostic studies reviewed include a Functional Capacity Evaluation dated 08/21/2013 with the following conclusion: At this time, based on evaluation, the patient does not appear to be ready to resume his normal job duties as a bus driver and will be on modified work due to his limitation and restriction to his injury. An MRI of the thoracic spine dated 08/26/2013 revealed moderate decrease in the AP saggital diameter of the thoracic spine secondary to a 5 mm posterior protrusion at T5-T6 intervertebral space. This is associated with a well circumscribed 8 mm area of bright signal intensity in the mid portion of the T7 thoracic vertebra representing a benign Hemangioma. PR-2 dated 09/20/2013 documented the patient to have complaints in the upper/mid back, bilateral shoulders of slight pain and intermittent pushing; pulling and repetitive movements increase the pain. States therapy is helping to reduce the pain. Objective findings on exam reveal slight tenderness on palpation of the thoracic and lumbar spine musculature. There is moderately reduced range of motion with pain. Schepelmann's test is positive and positive Apley's scratch test. Diagnoses: 1) Thoracic spine discopathy (per MRI). 2) Bilateral shoulders rotator cuff tear. Orthopedic Consult note dated 10/16/2013 documented the patient reporting on and off pain in thoracic spine. The patient describes the pain as tender and burning. He rates the pain 3/10. The pain also increased with sitting, standing and bending. Objective findings on examination of the cervical spine reveals decreased lordosis. There is no asymmetry of the web outline of the neck. Palpation of the cervical spine reveals tightness, spasm, muscle guarding at trapezius, sternocleidomastoid and strap muscles. There is no sub-occipital triangle tenderness. There is no

tenderness of the spinal processes of cervical vertebrae. There is no evidence of swelling of supraclavicular fossa. Negative Spurling's test and negative foramina compression test.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **CHIRO 2 X 6 THORACIC SPINE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION Page(s): 58-59.

**Decision rationale:** According to the CA MTUS Guidelines, manual therapy & manipulation is recommended for chronic pain if caused by musculoskeletal conditions. The intended goal is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The medical records documented the patient was diagnosed with thoracic spine discopathy, received prior unspecified amount of manual therapy and manipulation without any significant gain. In the absence of documented evidence of objective functional improvement or pain reduction, the request is not medically necessary. Chiropractic is not medically necessary.

#### **BIOFEEDBACK 2 X 6 THORACIC SPINE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines BIOFEEDBACK Page(s): 24-25.

**Decision rationale:** According to the CA MTUS Guidelines, biofeedback is recommended as an option in cognitive behavioral therapy (CBT) program to facilitate exercise therapy and return to activity. There is fairly good evidence that biofeedback helps in back muscle strengthening, but evidence is insufficient to demonstrate the effectiveness of biofeedback for treatment of chronic pain. The medical records document the patient was diagnosed with thoracic spine discopathy. On 10/16/2013 orthopedic consultation report documented the patient had intermittent pain with intensity 3/10 of VAS. On physical examination: there was tenderness to palpation para-spinal region but no motor or neurological deficit reported. Records stated the patient was participating in biofeedback sessions. However, the number of sessions received and functional improvement was not documented. It is not clear if treatment facilitated exercise therapy or what, if any, barriers existed to routine exercise therapy. Medical necessity has not been established. Biofeedback is not medically necessary.

#### **ORTHO CONSULT: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2NDEDITION, (2004) CHAPTER 7, INDEPENDENT MEDICAL EXAMINATIONS AND CONSULTATIONS, PAGE(S) 503.

**Decision rationale:** According to the ACOEM Practice Guidelines, IMEs consultation is recommended if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. It appears the patient was referred to orthopedics for evaluation and treatments of bilateral shoulder complaints. MRI's revealed B shoulder rotator cuff tears. Surgery was recommended. Therefore, orthopedics consult was medically necessary and is approved.

**ACUPUNCTURE 2 X 6 THORACIC SPINE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** According to the CA MTUS Guidelines, acupuncture is recommended as an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The medical records document the patient was diagnosed with thoracic spine discopathy, the patient received unspecified number of sessions of acupuncture treatment without significant improvement. The patient was on other modalities of treatment such as physical therapy and pain medication along with acupuncture treatment. There is no documented objective functional benefit or reduction in pain attributable to acupuncture. Thus, acupuncture is not medically necessary.