

Case Number:	CM13-0065811		
Date Assigned:	01/03/2014	Date of Injury:	07/19/2013
Decision Date:	04/23/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/13/2013

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 & Rehabilitation, and is licensed to practice in Texas. 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 36-year-old female who reported an injury on 07/19/2013. The mechanism of injury was noted to be the patient slipped and fell down 4 or 5 stairs. The evaluation on 11/11/2013 indicated that the patient's complaints were moderate to severe pain that was constant in the shoulder and arm on the left side and in the neck and low back bilaterally. The patient had physical therapy 6 times per week with temporary benefit and chiropractic care 6 times per week and TENS unit 6 times per week with temporary benefit. The patient's medications were Naprosyn and Cyclobenzaprine. The physical examination revealed the patient had spasms in the trapezius and paraspinous region of the cervical spine along with tenderness in the trapezius and paraspinous region. The lumbar examination revealed the patient had spasms in the quadratus and paraspinous region and the straight leg raise examination was positive on the left. The patient had decreased range of motion on the left shoulder and sensation was decreased to touch. The patient was scheduled for EMG/NCV studies on 11/26/2013. The patient's diagnoses were noted to include cervical disc displacement, and cervical and lumbar sprain and strain. The recommendation and treatment plan included acupuncture with electro-therapy 2 times a week for 4 weeks, MRI for the cervical spine, lumbar spine, and left shoulder, and a cortisone injection for the left shoulder, as well as medications including Mobic and Flexeril.

IMR ISSUES, DECISIONS AND RATIONALES

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

INFRARED FOR CERVICAL AND LUMBAR SPINE TWO TIMES A WEEK FOR FOUR WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

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

Decision rationale: Per the Official Disability Guidelines, infrared therapy is not recommended over other heat therapies. There was documented evidence that the patient had attended physical therapy, which provided temporary benefit. The submitted request was for electro-acupuncture. Given the above, and the lack of clarity, the request for Infrared for cervical and lumbar spine, two (2) times a week for four (4) weeks is not medically necessary and appropriate.

MYOFASCIAL RELEASE FOR THE CERVICAL AND LUMBAR SPINE TWO TIMES A WEEK FOR FOUR WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

Decision rationale: MTUS Chronic Pain Guidelines recommend massage therapy limited to 4 to 6 visits in most cases. The clinical documentation submitted for review indicated the patient had 6 sessions of physical therapy, which had limited benefits. There was documented evidence that the patient had attended physical therapy, which provided temporary benefit. The submitted request was for electro-acupuncture. Given the above and the lack of clarity, the request for Myofascial release for the cervical and lumbar spine two (2) times a week for four (4) weeks is not medically necessary and appropriate

MRI OF THE CERVICAL SPINE, LUMBAR SPINE, AND LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

Decision rationale: ACOEM Guidelines indicate that the criteria for ordering imaging studies are the emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient to warrant imaging studies if symptoms persist. The clinical

documentation submitted for review indicated the patient had decreased sensation to touch in the left shoulder. There was a lack of documentation including specific myotomal or dermatomal findings and that the patient had a failure to progress in a strengthening program or that the study was for a clarification of the anatomy prior to an invasive procedure. Given the above, the request for MRI of the cervical spine, lumbar spine, and left shoulder is not medically necessary.

ONE CORTISONE INJECTION OF THE LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

Decision rationale: ACOEM Guidelines indicate corticosteroid injections into the subacromial bursa are appropriate for impingement syndrome. The patient had decreased range of motion in the shoulder on the left side. The patient's physical examination failed to indicate the patient had findings of impingement on objective examination. Given the lack of documentation, the request for One (1) cortisone injection of the left shoulder is not medically necessary