

Case Number:	CM14-0107489		
Date Assigned:	08/01/2014	Date of Injury:	08/26/2013
Decision Date:	08/29/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/10/2014

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 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 injured worker is a 50-year-old female who reported a forward fall on 08/26/2013. On 03/05/2014, her complaints included constant left shoulder pain rated at 5/10 with associated numbness and tingling. She reported that the pain increased at night and then decreased with rest. She experienced difficulty driving, grasping things with her left hand, brushing her teeth or hair and carrying grocery bags. On examination, tenderness to palpation with spasms of the left upper trapezius and left rhomboid muscle with tenderness to palpation of the left AC joint were noted. Her ranges of motion of the shoulder measured in degrees were flexion 80/180, abduction 100/80, extension 35/50, adduction 10/40, internal rotation 60/80, and external rotation 80/90. An MRI of the left shoulder on 03/23/2014 revealed supraspinatus tendinosis, subscapularis tendinosis and partial tendon tear, posterior labral tear, bursitis, joint effusion, and some joint osteoarthritis. On 04/24/2014, her diagnoses included left shoulder sprain/strain, left shoulder myospasms, left eye laceration, tendinosis, subscapularis and partial tendon tear, bursitis, joint effusion, osteoarthritis, and insomnia. The treatment plan included recommendations for chiropractic treatment and acupuncture. The records stated that she was not taking any oral medications but was given transdermal compounds of an unknown nature. She was released to return to work with modified duty. On 05/19/2014, her complaints included (in addition to the left shoulder complaints) intermittent and frequent worsening headaches associated with worsening memory loss, blurry vision, and dizziness. She further complained of increasing left knee pain which she described as mild but occasionally moderate which was increased with prolonged walking, standing, or climbing. The treatment plan included continuing with the chiropractic and acupuncture treatments that were recommended in the previous visit. Also included in the treatment plan was a request for magnetic resonance imaging (MRI) of the brain and a neurological consultation, as well as a hot and cold pack/wrap or thermal combo unit. The

MRI of the brain on 06/22/2014 showed microangiopathic disease but otherwise unremarkable. The recommendations in an orthopedic consultation from 07/11/2014 included left shoulder subacromial decompression and labral repair. There was no rationale or request for authorization included in this worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment with Chiropractic Supervised Physiotherapy, Twice weekly for six (6) weeks QTY:12 (unspecified body part):

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation; Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation, pages 58-60 Page(s): 58-60.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) Guidelines recommends chiropractic for pain if caused by musculoskeletal conditions. The intended goal or effect of manual medicine 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 treatment parameters indicate that the time to produce a positive effect is 4 to 6 treatments with a frequency of 1 to 2 times per week for the first 2 weeks. Treatment may continue at 1 treatment per week for the next 6 weeks with a maximum duration of 8 weeks. Extended durations of care beyond what is considered maximum, may be necessary in cases of reinjury, interrupted continuity of care, exacerbations of symptoms, and in those patients with comorbidities. Treatments beyond 4 to 6 visits should be documented with objective improvement in function. This worker was already involved in 6 sessions of chiropractic treatments with no measurable or quantifiable notations of increased function or decreased pain. Additionally, the body part to which the chiropractic therapy was to have been performed was not specified and the requested number of treatment exceeds the recommendations in the guidelines. Therefore, this request for Chiropractic Treatment with Chiropractic Supervised Physiotherapy, Twice weekly for six (6) weeks QTY:12 (unspecified body part) is not medically necessary and appropriate.

Acupuncture Twice weekly for six (6) weeks QTY:12 (unspecified body parts): Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) Guidelines recommend that acupuncture is 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 recommended frequency of treatments is 1 to 3 times per week with

functional improvement noted in 3 to 6 treatments. The optimum duration of treatments is 1 to 3 months. Treatments may be extended if functional improvement is documented. This worker had participated in 6 treatments of acupuncture with no documentation of functional improvement or decreased pain. In addition, she was not taking any oral medications and surgery was recommended, but there was no documentation of the surgery every having taken place. Furthermore, the body parts which were to have been treated, were not specified. Therefore, this request for Acupuncture Twice weekly for six (6) weeks QTY:12 (unspecified body parts) is not medically necessary and appropriate.

Range of Motion and Muscle Testing QTY:1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation DopfCA, Mandel SS, Geiger DF, Mayer PJ, Spine. 1995 Jan 15;20(2):252-3.;Comprehensive Muscular Activity Profile (CMAP);Gatchel RJ, Ricard MD, Choksi DN, Mayank J, Howard K. J Occup Rehabil. 2009 Mar;19(1):49-55. Epub 2008 Nov15.

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 - Lumbar & Thoracic, Flexibility and Forearm, Wrist, & Hand, Computerized muscle testing.

Decision rationale: The Official Disability Guidelines do not recommend computerized muscle testing. There are no studies to support computerized strength testing of the extremities. The extremities have the advantage of comparison to the other side, and there is no useful application of such a potentially sensitive computerized test. Deficit definition is quite adequate with usual exercise equipment given the physiological reality of slight performance variation day to day due to a multitude of factors that always vary human performance. This would be an unneeded test. Range of motion testing is likewise not recommended, but should be a part of a routine musculoskeletal evaluation. Guidelines state that an inclinometer is the preferred device for obtaining accurate reproducible measurements in a simple, practical and inexpensive way. They do not recommend computerized measures where the result is of unclear therapeutic value. Additionally, there was no body part specified in the request to be tested. The clinical information submitted fails to meet the evidence based guidelines for range of motion and muscle testing. Therefore, this request for Range of Motion and Muscle Testing QTY:1 is not medically necessary and appropriate.

Neurological Consultation QTY:1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Treatment in Workman's Compensation (TWC): Pain Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89.

Decision rationale: California American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition Guidelines suggest that under the optimal system, a clinician acts as the primary case manager. The clinician provides appropriate medical evaluation and treatment and adheres to a conservative evidence based treatment approach that limits excessive physical medicine usage and referral. The clinician should judiciously select and refer to specialists who will support functional recovery as well as provide expert medical recommendations. The MRI of this workers brain was unremarkable. There were no quantified measures of neurological deficits included in her chart. There is no justification or documentation as to why the neurological consult was necessary. Therefore, this request for Neurological Consultation QTY:1 is not medically necessary and appropriate.

Aqua Relief System for Purchase QTY:1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -Treatment in Workman's Compensation (TWC): Shoulder Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Thermotherapy, Cold packs and Knee & Leg, Durable medical equipment (DME).

Decision rationale: Official Disability Guidelines (ODG) recommend that thermotherapy is under study. For several physical therapy interventions and indications, there was a lack of documentation regarding efficacy. Cold packs however, are recommended. Regarding durable medical equipment, the Official Disability Guidelines recommend Durable medical equipment (DME) generally if there is a medical need and if the device or system meets Medicare's definition of DME, defined as equipment which can withstand repeated use, for example, could normally be rented and used by successive patients and is primarily and customarily used to serve a medical purpose. The submitted documentation does state that this worker has failed conservative treatment with anti-inflammatories and physical therapy for more than half a year. The modalities and medications were not mentioned. There was no documentation of failed trials with antidepressants, antiepileptics, or muscle relaxants. Additionally, the recommendation was for surgery. The clinical information submitted failed to meet the evidence based guidelines for this system. Therefore, this request for Aqua Relief System for Purchase QTY:1 is not medically necessary and appropriate.