

Case Number:	CM14-0016969		
Date Assigned:	03/07/2014	Date of Injury:	03/01/2013
Decision Date:	05/28/2014	UR Denial Date:	01/29/2014
Priority:	Standard	Application Received:	02/10/2014

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 Orthopedic Surgery 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 injured worker is a 51-year-old male who reported an injury on 03/01/2013. The mechanism of injury was not provided. Current diagnoses include cervical sprain, displacement of cervical intervertebral disc without myelopathy, cervicgia, lumbar sprain, displacement of lumbar intervertebral disc without myelopathy, sprain of the left shoulder, and pain in a joint involving the shoulder region. The injured worker was evaluated on 12/31/2013. The injured worker reported persistent shoulder and lower back pain. The injured worker has received chiropractic treatment for 19 weeks, including myofascial release. Current medications include ibuprofen 800 mg. Physical examination revealed moderate tenderness at the acromioclavicular joint and supraspinatus on the left, positive impingement testing, limited shoulder range of motion, tenderness to palpation of the cervical spine, normal range of motion of the cervical spine, moderate paraspinal tenderness in the lumbar spine, spasm in the lumbar spine, reduced range of motion of the lumbar spine, and positive straight leg raising. Treatment recommendations included continuation of chiropractic therapy for 6 weeks to include electrical stimulation, infrared therapy, and myofascial release. Recommendations also included a follow-up with an orthopedic specialist and a pain management consultation. **IMR DECISION(S) AND RATIONALE**

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR 6 ELECTRICAL STIMULATION VISITS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, (Acute & Chronic).

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

Decision rationale: California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain if caused by a musculoskeletal condition. Treatment for the spine is recommended as a therapeutic trial of 6 visits over 2 weeks. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. The requesting provider has recommended 6 sessions of chiropractic therapy with electrical stimulation, diathermy, and myofascial release with joint mobilization. However, the injured worker has participated in 19 weeks of chiropractic therapy. There is no evidence of objective functional improvement as a result of the previous course of treatment. Therefore, ongoing therapy cannot be determined as medically appropriate. There is also no specific body part listed in the current request. Therefore, the request is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR 6 DIATHERMY THERAPY VISITS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, (Acute & Chronic).

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

Decision rationale: California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain if caused by a musculoskeletal condition. Treatment for the spine is recommended as a therapeutic trial of 6 visits over 2 weeks. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. The requesting provider has recommended 6 sessions of chiropractic therapy with electrical stimulation, diathermy, and myofascial release with joint mobilization. However, the injured worker has participated in 19 weeks of chiropractic therapy. There is no evidence of objective functional improvement as a result of the previous course of treatment. Therefore, ongoing therapy cannot be determined as medically appropriate. There is also no specific body part listed in the current request. Therefore, the request is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR 6 MYOFASCIAL RELEASE/SOFT TISSUE THERAPY VISITS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 146.

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

Decision rationale: California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain if caused by a musculoskeletal condition. Treatment for the spine is recommended as a therapeutic trial of 6 visits over 2 weeks. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. The requesting provider has recommended 6 sessions of chiropractic therapy with electrical stimulation, diathermy, and myofascial release with joint mobilization. However, the injured worker has participated in 19 weeks of chiropractic therapy. There is no evidence of objective functional improvement as a result of the previous course of treatment. Therefore, ongoing therapy cannot be determined as medically appropriate. There is also no specific body part listed in the current request. Therefore, the request is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR 6 JOINT MOBILIZATION VISITS: 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 Page(s): 58.

Decision rationale: California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain if caused by a musculoskeletal condition. Treatment for the spine is recommended as a therapeutic trial of 6 visits over 2 weeks. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. The requesting provider has recommended 6 sessions of chiropractic therapy with electrical stimulation, diathermy, and myofascial release with joint mobilization. However, the injured worker has participated in 19 weeks of chiropractic therapy. There is no evidence of objective functional improvement as a result of the previous course of treatment. Therefore, ongoing therapy cannot be determined as medically appropriate. There is also no specific body part listed in the current request. Therefore, the request is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR 1 MONTH TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION UNIT FOR HOME: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

Decision rationale: California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based trial may be considered as a noninvasive conservative option. There should be evidence that other appropriate pain modalities have been tried and failed. As per the documentation submitted, there is no indication of a failure to respond to other appropriate pain modalities, including medication. There was also no treatment plan including the specific short and long-term goals of treatment

with the TENS unit provided for review. Therefore, the injured worker does not meet criteria for the requested durable medical equipment. As such, the request is not medically necessary and appropriate.

RETROSPECIBE REQUEST FOR ONE X-RAY OF CERVICAL SPINE, LUMBAR SPINE AND LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179, 303-305, 207-209.

Decision rationale: California MTUS/ACOEM Practice Guidelines state for most patients presenting with true neck or upper back problems, special studies are not needed unless a 3 to 4 week period of conservative care and observation fails to improve symptoms. Lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. For most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. As per the documentation submitted, there is no evidence of a failure to respond to conservative treatment for the cervical spine, lumbar spine, and left shoulder. Therefore, the medical necessity for the requested service has not been established. As such, the request is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR 1 FUNCTIONAL CAPACITY TESTING: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cornerstones of Disability Prevention and Management, pages 89-92. Additionally, Official Disability Guidelines (ODG) Fitness for Duty Chapter, Functional Capacity Evaluation

Decision rationale: California MTUS Guidelines state a number of functional assessment tools are available, including Functional Capacity Examination, when re-assessing function and functional recovery. Official Disability Guidelines state a Functional Capacity Evaluation may be indicated if case management is hampered by complex issues, and the timing is appropriate. There is no documentation of previous unsuccessful return to work attempts. There is also no indication that this injured worker is close to or at maximum medical improvement. Therefore, the medical necessity has not been established. As such, the request is not medically necessary and appropriate.

RETROSPECTIVE REQUEST FOR 1 ORTHOPEDIC CONSULT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cornerstones of Disability Prevention and Management, pages 89-92.

Decision rationale: California MTUS Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. There is no documentation of an exhaustion of conservative treatment prior to the request for a specialty referral. The medical necessity of the requested service has not been established. As such, the request is not medically necessary and appropriate.