

Case Number:	CM14-0138895		
Date Assigned:	09/05/2014	Date of Injury:	06/03/2013
Decision Date:	10/02/2014	UR Denial Date:	08/06/2014
Priority:	Standard	Application Received:	08/27/2014

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 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:

According to the records made available for review, this is a 32-year-old male with a 6/3/13 date of injury. At the time (6/16/14) of request for authorization for Chiropractic Treatment 2 x 6 weeks, Cervical Spine and Right Shoulder, EMG of the Bilateral Upper Extremities, NCV of the Bilateral Upper Extremities, and Physiotherapy 2 x 6 weeks, Cervical Spine and Right Shoulder, there is documentation of subjective (persistent neck pain and right shoulder pain) and objective (decreased cervical range of motion with pain; painful right shoulder range of motion with tenderness to palpation over the acromioclavicular joint, lateral shoulder and posterior shoulder, and positive impingement signs of the right shoulder) findings, current diagnoses (cervical disc protrusion, cervical sprain/strain, rule out cervical radiculitis versus radiculopathy, right shoulder pain, right shoulder sprain/strain, and rule out right shoulder internal derangement), and treatment to date (at least 14 physical therapy and chiropractic therapy sessions). In addition, medical report identifies that physical and chiropractic therapy is providing pain relief. Regarding Chiropractic Treatment 2 x 6 weeks, Cervical Spine and Right Shoulder, there is no (clear) documentation of positive symptomatic or objective measurable gains in functional improvement with previous treatment; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of chiropractic treatments to date. Regarding EMG of the Bilateral Upper Extremities and NCV of the Bilateral Upper Extremities, there is no documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. Regarding Physiotherapy 2 x 6 weeks, Cervical Spine and Right Shoulder, there is no documentation of remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a

reduction in the use of medications or medical services as a result of physical therapy provided to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment 2 x 6 weeks, Cervical Spine and Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & manipulation Page(s): 58. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that manual therapy/manipulation is recommended for chronic pain if caused by musculoskeletal conditions, and that 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. MTUS additionally supports a total of up to 18 visits over 6-8 weeks. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of cervical disc protrusion, cervical sprain/strain, and rule out cervical radiculitis versus radiculopathy, right shoulder pain, right shoulder sprain/strain, and rule out right shoulder internal derangement. In addition, there is documentation of at least 14 previous chiropractic treatments. However, despite documentation of pain relief with previous chiropractic treatments, there is no (clear) documentation of positive symptomatic or objective measurable gains in functional improvement with previous treatment; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of chiropractic treatments to date. Therefore, based on guidelines and a review of the evidence, the request for Chiropractic Treatment 2 x 6 weeks, Cervical Spine and Right Shoulder is not medically necessary.

EMG of the Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177;33.

Decision rationale: MTUS reference to ACOEM identifies documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment, as criteria necessary to support the medical necessity of EMG/NCV. Within the medical information available for review, there is documentation of diagnoses of cervical disc protrusion, cervical sprain/strain, and rule out cervical radiculitis versus radiculopathy, right shoulder pain, right shoulder sprain/strain, and rule out right shoulder internal derangement. However, despite documentation of subjective (persistent neck pain and right shoulder pain) and objective (decreased cervical range of motion with pain; painful right shoulder range of motion with tenderness to palpation over the acromioclavicular joint, lateral shoulder and posterior shoulder, and positive impingement signs of the right shoulder) findings, and given documentation of the associated requests for chiropractic and physical therapy, there is no documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. Therefore, based on guidelines and a review of the evidence, the request for EMG of the Bilateral Upper Extremities is not medically necessary.

NCV of the Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177;33.

Decision rationale: MTUS reference to ACOEM identifies documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment, as criteria necessary to support the medical necessity of EMG/NCV. Within the medical information available for review, there is documentation of diagnoses of cervical disc protrusion, cervical sprain/strain, rule out cervical radiculitis versus radiculopathy, right shoulder pain, right shoulder sprain/strain, and rule out right shoulder internal derangement. However, despite documentation of subjective (persistent neck pain and right shoulder pain) and objective (decreased cervical range of motion with pain; painful right shoulder range of motion with tenderness to palpation over the acromioclavicular joint, lateral shoulder and posterior shoulder, and positive impingement signs of the right shoulder) findings, and given documentation of the associated requests for chiropractic and physical therapy, there is no documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. Therefore, based on guidelines and a review of the evidence, the request for NCV of the Bilateral Upper Extremities is not medically necessary.

Physiotherapy 2 x 6 week, Cervical Spine and Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back; Shoulder, Physical therapy Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of cervical sprain/strain and shoulder sprain/strain not to exceed 10 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of cervical disc protrusion, cervical sprain/strain, rule out cervical radiculitis versus radiculopathy, right shoulder pain, right shoulder sprain/strain, and rule out right shoulder internal derangement. In addition, there is documentation of previous physical therapy. However, given documentation of at least 14 sessions of physical therapy completed to date, which exceeds guidelines, there is no documentation of remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines. In addition, despite documentation of pain relief with previous physical therapy, there is no (clear) documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for Physiotherapy 2 x 6 weeks, Cervical Spine and Right Shoulder is not medically necessary.