MAXIMUS Federal Services

Case Number:	CM14-0048423		
Date Assigned:	07/11/2014	Date of Injury:	04/01/1995
Decision Date:	08/27/2014	UR Denial Date:	04/09/2014
Priority:	Standard	Application Received:	04/16/2014

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 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 56-year-old female who has submitted a claim for cervical intervertebral disc syndrome and cervicothoracic segmental dysfunction associated with an industrial injury date of April 1, 1995. Medical records from 2013 were reviewed. The patient complained of constant neck, upper back, left shoulder and headache pain, rated 9/10 in severity. There was also left greater than the right arm to hand pain and numbness. Physical examination showed restricted cervicothoracic range of motion with increased pain. There was positive cervical compression and Soto Hall. Cervicothoracic paraspinal hypertonicity on occiput-C1, C5-C6, and T1-3 +4 left trapezius was noted as well. An MRI of the cervical spine, dated October 20, 2010, revealed multiple disc protrusions, and moderate canal stenosis towards the left at C5-C6 and multiple levels of neural foraminal narrowing. Treatment to date has included medications, physical therapy, TENS unit, chiropractic care, home exercise program, and activity modification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound x 1: Upheld

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), 2nd Edition, (2004), Special Studies and Diagnostic and Treatment Considerations, pages 557-559, 561-563; Official Disability Guidelines (ODG), Shoulder Chapter, Ultrasound, diagnostic.

Decision rationale: As stated on pages 557-563 of the ACOEM Practice Guidelines, in most patients with shoulder problems, special studies are not needed unless a four- to six-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided red-flag conditions are ruled out. In addition, the Official Disability Guidelines states that ultrasound of the shoulder in clinical examination can rule out the presence of a rotator cuff tear, and that either MRI or ultrasound could equally be used for detection of full-thickness rotator cuff tears. In this case, the patient complained of left shoulder pain. The rationale for the present request was not provided. There was no documented failure of conservative treatment. Furthermore, the most recent clinical evaluation does not document subjective and objective findings that would suggest new onset shoulder pathology. The medical necessity for further investigation with ultrasound was not established. Furthermore, the present request failed to specify the body part to be subjected for imaging. Therefore, the request is not medically necessary.

Elect. Stim x4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

Decision rationale: As noted on page 114 of the California MTUS Chronic Pain Medical Treatment Guidelines, transcutaneous electrotherapy includes TENS, interferential current stimulation, microcurrent electrical stimulation, neuromuscular electrical stimulation, RS-4i sequential stimulator, electroceutical therapy, and sympathetic therapy. In this case, the rationale for the request was not provided. There is no documentation of failure of medications and conservative management strategies that would necessitate an electrical stimulation unit. Also, the specific modalities included in this request were not indicated. Furthermore, the present request failed to specify the body part to be treated, and if the device is for rental or purchase. Therefore, the request is not medically necessary.

Chiropractic Manipulative Therapy x1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 62.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173,Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

Decision rationale: The California MTUS/ACOEM states that using cervical manipulation may be an option for patients with neck pain or cervicogenic headache, but there is insufficient evidence to support manipulation of patients with cervical radiculopathy. In addition, the California MTUS Chronic Pain Medical Treatment Guidelines recommended manipulation therapy for chronic pain if caused by musculoskeletal conditions. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. There should be evidence of objective functional improvement with previous treatment and a total of up to 18 visits is supported. In this case, the patient previously had an unspecified number of chiropractic therapy sessions since 1995. However, objective evidence such as decrease in pain score, improvement in functionality with activities of daily living, and decrease in medication use were not documented. Furthermore, it was not clear whether the previous chiropractic sessions exceeded the recommended total number of visits. Furthermore, the most recent progress report was dated November 2013. The current clinical functional status of the patient is not known. Moreover, the present request failed to specify the body part to be treated. Therefore, the request is not medically necessary.

Chiropractic treatment x1: Upheld

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