

<b>Case Number:</b>	CM14-0206529		
<b>Date Assigned:</b>	12/16/2014	<b>Date of Injury:</b>	10/26/2011
<b>Decision Date:</b>	03/03/2015	<b>UR Denial Date:</b>	11/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 61 year old female who was injured on 10/26/11 while receiving a cumulative trauma injury from looking down at the table for prolonged periods of time causing injury to her neck. She also injured her shoulders bilaterally from doing assembly on the table for prolonged periods. She has been diagnosed with C5-6 disc herniation per MRI, Cervical radiculitis C6 per EMG, Cervical enthesopathy, cervicgia, tenosynovitis hand, lateral epicondylitis, superior glenoid labrum tear, post surgical bilateral supraspinatus tendon tear. Patient has been treated with medications, physical therapy, and surgery to the shoulders. The orthopedic surgeon has requested a cervical C5-6 anterior cervical discectomy and fusion. The patient has a complication of Diabetes. The patient has also had a left cubital tunnel release. The doctor has requested treatment of therapeutic exercise for 12 sessions to unknown areas of injury for no specific time period, 12 chiropractic manipulations with no areas of injury to be treated for unspecified length of time, 12 EMS/mechanical traction to unknown areas with no time period, 12 temperature gradient treatments to unknown areas with no time period, one sensory test with no specification as to upper or lower extremity(most likely upper but the request should be clear). Also there was no mention of when the surgeries were performed to the shoulders and left wrist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic manipulation, qty. 12: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

**Decision rationale:** The request for chiropractic manipulation, qty. 12 is not medically necessary. The California MTUS Guidelines state manual therapy is recommended for musculoskeletal pain. The guidelines recommend 4 to 6 treatments to produce effect. The included documentation noted that the patient was previously approved for 6 sessions of chiropractic therapy. However, there was no evidence of functional improvement and objective measurable gains with the prior therapy. In addition, the request exceeds the guideline recommendations. As such, medical necessity has not been established.

**EMS/mechanical traction, qty. 12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-116.

**Decision rationale:** The request for EMS/mechanical traction, qty. 12 is not medically necessary. The California MTUS Guidelines recommend transcutaneous electrical nerve stimulations, however it is not recommended as a primary treatment modality. A 1 month home based trial may be considered as an adjunct to a program of evidence based functional restoration. There is no evidence that the patient had tried a 1 month in home based trial. Additionally, there is no evidence that the patient would be participating in an active treatment program in addition to EMS unit. The site at which the EMS mechanical traction unit was indicated for was not provided in the request as submitted. As such, medical necessity has not been established.

**Temperature gradient, qty. 12: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Pain 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) Pain, Thermography (infrared stress thermography).

**Decision rationale:** The request for temperature gradient, qty. 12 is not medically necessary. The Official Disability Guidelines state thermography is not recommended. The technique is

intended to measure temperature distribution to various organs and tissues. There was no rationale provided for the requested treatment. Additionally, the request is not supported by the referenced guidelines. As such, medical necessity has not been established.

**Sensory test, qty. 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation ODG-TWC, Neck & Upper Back Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The request for sensory test, qty. 1 is not medically necessary. According to the California MTUS Guidelines, special studies and diagnostic tests must be warranted for patients with true upper neck problems. However, they are not needed unless a 3 to 4 week period of conservative care and observation has failed to improve symptoms. Criteria for ordering imaging studies include evidence of a red flag, physiologic evidence of a tissue insult or neurologic dysfunction or failure to progress in a strengthening program intended to avoid surgery. The injured worker was indicated to have shoulder pain. However, there was no evidence that the injured worker has tried and failed initially recommended conservative care and treatment. There is no evidence of an emergence of a red flag or neurologic dysfunction. As such, a sensory test would not be supported by the referenced guidelines. As such, medical necessity has not been established.