

<b>Case Number:</b>	CM14-0040080		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	10/20/2013
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	03/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/04/2014

### 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

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 32 year old male who sustained an industrial injury on 10/20/2013. Diagnoses include cervico-brachial syndrome, myofascitis/myositis, thoracalgia, thoracic myofascitis/myositis, and post traumatic chest pain. Treatment to date has included medications, and chiropractic sessions. A physician progress note dated 03/04/2014 documents the injured worker complains of neck, chest and anterior right shoulder pain. Neck pain is rated as a 6 on a scale of 1 to 10. The pain is explained as aching and occurring nearly constantly. The injured worker has chest discomfort. Upon palpitation there appears to be a soft tissue mass in that region. He is complaining of anterior right shoulder pain the pain is described as sharp, stabbing and deep. He has cervical and shoulder decreased range of motion. Cervical compression, Foraminal Compressing bilaterally and Jackson's Compression bilaterally were positive. Soto hall test was positive, and shoulder depressor was positive on the left and right. Treatment requested is for EMS (Electrical Muscle Stimulation) for the Neck and Chest 2 times per week for 4 weeks, Myofascial Release for the neck and chest 2 times per week for 4 weeks, Ultrasound for the Neck and Chest 2 times per week for 4 weeks, and Work Conditioning program for the neck and chest 2 times per week for 4 weeks. On 03/24/2014 Utilization Review non-certified the request for EMS (Electrical Muscle Stimulation) for the Neck and Chest 2 times per week for 4 weeks, California Medical Treatment Utilization Schedule-Chronic Pain Treatment Guidelines. Myofascial Release for the neck and chest 2 times per week for 4 weeks was non-certified and cited was California Medical Treatment Utilization Schedule-Chronic Pain Treatment Guidelines. The request for Ultrasound for the Neck and Chest 2 times per week for

4 weeks was non-certified and cited was California Medical Treatment Utilization Schedule-Chronic Pain Treatment Guidelines. The request for Work Conditioning program for the neck and chest 2 times per week for 4 weeks was non-certified and cited was California Medical Treatment Utilization Schedule-Chronic Pain Treatment Guidelines.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Work Conditioning program for the neck and chest 2 times per week for 4 weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines work conditioning/work hardening Page(s): 125-126. Decision based on Non-MTUS Citation Official disability guidelines Neck and Upper back chapter, under Functional capacity evaluation FCE.

**Decision rationale:** The patient presents with constant moderate neck pain rated 6/10, chest discomfort, unrated anterior right shoulder pain. The patient's date of injury is 10/20/13. Patient has no documented surgical history directed at this complaint. The request is for WORK CONDITIONING PROGRAM FOR THE NECK AND CHEST 2 TIME PER WEEK FOR 4 WEEKS. The RFA is dated 03/11/14. Physical examination dated 03/11/14 reveals tenderness to palpation of the right AC joint, and a palpable soft tissue mass in the right pectoral region. Cervical examination reveals positive cervical compression test, foraminal compression test, Jackson's compression test, Soto Hall test, and shoulder depressor test bilaterally. The patient's current medication regimen was not provided. Diagnostic imaging was not included. Patient is currently working modified duties. The MTUS Guidelines page 125 on work conditioning/work hardening recommends this as an option depending on the availability of quality program. The criteria for admission to work hardening program include among others a functional capacity evaluation to determine the patient's maximum effort, a job to return to or on the job training, etc. ODG Neck and Upper back chapter, under Functional capacity evaluation FCE states: "Recommended prior to admission to a Work Hardening Program, with preference for assessments tailored to a specific task or job. Not recommend routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally." In regards to the request for a work conditioning program to improve this patient's overall workplace functionality, the treater has not provided a reason for the request. Progress note dated 03/14/14; the only note for the year 2014 provided; indicates that this patient has already returned to work, albeit with modified duties. There is no documentation of the completion of the prerequisite functional capacity evaluation. There is no discussion provided as to whether this patient's employer has requested such a program. It is unclear why this patient requires such a program or why traditional physical therapy/home based exercise is inadequate. Therefore, the request IS NOT medically necessary.

**Ultrasound for the Neck and Chest 2 times per week for 4 weeks: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Neck and Upper Back chapter, under therapeutic Ultrasound.

**Decision rationale:** The patient presents with constant moderate neck pain rated 6/10, chest discomfort, unrated anterior right shoulder pain. The patient's date of injury is 10/20/13. Patient has no documented surgical history directed at this complaint. The request is for ULTRASOUND FOR THE NECK AND CHEST 2 TIMES PER WEEK FOR 4 WEEKS. The RFA is dated 03/11/14. Physical examination dated 03/11/14 reveals tenderness to palpation of the right AC joint, and a palpable soft tissue mass in the right pectoral region. Cervical examination reveals positive cervical compression test, foraminal compression test, Jackson's compression test, Soto Hall test, and shoulder depressor test bilaterally. The patient's current medication regimen was not provided. Diagnostic imaging was not included. Patient is currently working modified duties. ODG Guidelines, Neck and Upper Back chapter, under therapeutic Ultrasound states: "Under study. There is little information available from trials to support the use of many physical medicine modalities for mechanical neck pain, often employed based on anecdotal or case reports alone. In general, it would not be advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated." In regards to the request for therapeutic ultrasound for this patient's chest and neck complaints, the treater has specified an excessive duration of therapy. This patient has not had any documented ultrasound therapy to date. ODG guidelines do not strongly recommend such treatments, though does support a 2-3 week trial of therapy and additional sessions provided documentation of functional improvement. In this case, the treater is prescribing a 4 week series of ultrasound treatments without a trial, guidelines only support a maximum of 3 weeks. Therefore, the request IS NOT medically necessary. In regards to the request for therapeutic ultrasound for this patient's chest and neck complaints, the treater has specified an excessive duration of therapy. This patient has not had any documented ultrasound therapy to date. ODG guidelines do not strongly recommend such treatments, though does support a 2-3 week trial of therapy and additional sessions provided documentation of functional improvement. In this case, the treater is prescribing a 4 week series of ultrasound treatments without a trial, guidelines only support a maximum of 3 weeks. Therefore, the request IS NOT medically necessary.

**Myofascial Release for the neck and chest 2 times per week for 4 weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

**Decision rationale:** The patient presents with constant moderate neck pain rated 6/10, chest discomfort, unrated anterior right shoulder pain. The patient's date of injury is 10/20/13. Patient has no documented surgical history directed at this complaint. The request is for MYOFASCIAL

RELEASE FOR THE NECK AND CHEST 2 TIMES PER WEEK FOR 4 WEEKS. The RFA is dated 03/11/14. Physical examination dated 03/11/14 reveals tenderness to palpation of the right AC joint, and a palpable soft tissue mass in the right pectoral region. Cervical examination reveals positive cervical compression test, foraminal compression test, Jackson's compression test, Soto Hall test, and shoulder depressor test bilaterally. The patient's current medication regimen was not provided. Diagnostic imaging was not included. Patient is currently working modified duties. The MTUS Chronic Pain Medical Treatment Guidelines, page 60 for Massage therapy states: Recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment e.g. exercise and it should be limited to 4-6 visits in most cases. In regards to the request for myofascial release to be performed on the neck and chest, the treater has specified an excessive number of visits. This patient has not had any documented myofascial release therapy to date. MTUS guidelines support myofascial release as an adjunct to other recommended treatments, though indicates that a maximum of 6 sessions is appropriate. In this case, the treater is requesting 8 sessions, which exceeds guideline recommendations. Therefore, the request IS NOT medically necessary.

**EMS(Electrical Muscle Stimulation) for the Neck and Chest 2 times per week for 4 weeks:**  
Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Neck and Upper Back Chapter, under Electrical Muscle Stimulation.

**Decision rationale:** The patient presents with constant moderate neck pain rated 6/10, chest discomfort, unrated anterior right shoulder pain. The patient's date of injury is 10/20/13. Patient has no documented surgical history directed at this complaint. The request is for EMS (ELECTRICAL MUSCLE STIMULATION) FOR THE NECK AND CHEST 2 TIMES PER WEEK FOR 4 WEEKS. The RFA is dated 03/11/14. Physical examination dated 03/11/14 reveals tenderness to palpation of the right AC joint, and a palpable soft tissue mass in the right pectoral region. Cervical examination reveals positive cervical compression test, foraminal compression test, Jackson's compression test, Soto Hall test, and shoulder depressor test bilaterally. The patient's current medication regimen was not provided. Diagnostic imaging was not included. Patient is currently working modified duties. ODG Guidelines, Neck and Upper Back Chapter, under Electrical Muscle Stimulation has the following: "Not recommended. The current evidence on EMS is either lacking, limited, or conflicting. There is limited evidence of no benefit from electric muscle stimulation compared to a sham control for pain in chronic mechanical neck disorders. Most characteristics of EMS are comparable to TENS. The critical difference is in the intensity, which leads to additional muscle contractions. Primary pain relief via gate control may be obtained by EMS, TENS, or other forms of ENS. The theory is that rhythmic muscle stimulation by modulated DC or AC probably increases joint range of motion, reeducates muscles, retards muscle atrophy, and increases muscle strength. Circulation can be increased and muscle hypertension decreased, which may lead to secondary pain relief. Since the quality of evidence is low or very low, we cannot make any definite statements on the

efficacy and clinical usefulness of electrotherapy modalities for neck pain. There is very low quality evidence that electric muscle stimulation is not more effective than placebo. EMS did not reduce pain or disability." In regards to the request for electrical muscle stimulation directed at this patient's neck and shoulder complaints, guidelines do not support such treatment modalities. This patient has not had any documented EMS therapy to date. While this patient presents with persistent chronic neck and chest pain following his injury, supervised EMS therapy is not supported by guidelines owing to a little or conflicting evidence of efficacy. Therefore, the request IS NOT medically necessary.