

Case Number:	CM15-0135886		
Date Assigned:	07/30/2015	Date of Injury:	03/04/2013
Decision Date:	10/05/2015	UR Denial Date:	06/12/2015
Priority:	Standard	Application Received:	07/14/2015

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: Emergency Medicine

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 55-year-old female who sustained an industrial injury on March 4, 2013. She has reported neck, upper back, and bilateral arm pain and has been diagnosed with bilateral shoulder pain and shoulder and neck pain. Treatment has included physical therapy. She had cervical discomfort. Objectively range of motion was 65 degrees to the left and 35 degrees right rotation. She freely grasped her keys, exercise equipment, items without hesitation. The treatments plan was for a TENS unit, therapeutic exercise EMS-TENS IR-IR traction, MRI cervical, therapeutic exercise EMS-IF-IR traction, FCE, massage, manual therapy, iontophoresis, and continued physical therapy for the cervical spine and bilateral shoulders. The treatment request included therapeutic Ex EMS-TENS-IF-IR traction, TENS unit, physical therapy for the cervical spine, physical therapy for the bilateral shoulders, massage, manual therapy, Iontophoresis, MRI of the cervical spine, functional capacity evaluation, and EMG for the upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit: Upheld

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

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

Decision rationale: The requested TENS unit, is not medically necessary. Chronic Pain Medical Treatment Guidelines, TENS, chronic, (transcutaneous electrical nerve stimulation), pages 114 - 116, note "Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration." The injured worker has cervical discomfort. The treating physician has documented range of motion was 65 degrees to the left and 35 degrees right rotation. The treating physician has not documented a current rehabilitation program, or objective evidence of functional benefit from electrical stimulation under the supervision of a licensed physical therapist nor home use. The criteria noted above not having been met, TENS unit is not medically necessary.

Therapeutic Ex EMS/TENS/IF/IR traction: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

Decision rationale: The requested Therapeutic Ex EMS/TENS/IF/IR traction is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 8, Neck and Upper Back Complaints, Special Studies, Diagnostic, and Therapeutic Considerations, Page 181, does not recommend cervical traction. The injured worker has cervical discomfort. The treating physician has documented range of motion was 65 degrees to the left and 35 degrees right rotation. The treating physician has not documented subjective or objective findings indicative of cervical radiculopathy, nor objective evidence of derived functional benefit from the use of cervical traction under the supervision of a licensed physical therapist. The criteria not having been met, the requested Therapeutic Ex EMS/TENS/IF/IR traction is not medically necessary.

MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-179.

Decision rationale: The requested MRI of the cervical spine is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 8, Neck and Upper Back Complaints, Special Studies and Diagnostic and Therapeutic Considerations, Pages 178-179, recommend imaging

studies of the cervical spine with "Unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option". The injured worker has cervical discomfort. The treating physician has documented range of motion was 65 degrees to the left and 35 degrees right rotation. The treating physician has not documented a history of acute trauma, nor physical exam evidence indicative of radiculopathy such as a Spurling's sign or deficits in dermatomal sensation, reflexes or muscle strength. The criteria not having been met, the requested MRI of the cervical spine is not medically necessary.

EMG for the upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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

Decision rationale: The requested EMG for the upper extremity is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 8, Neck and Upper Back Complaints, page 177-179, Special Studies and Diagnostic and Treatment Considerations, Special Studies and Diagnostic and Treatment Considerations, note "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study." The injured worker has cervical discomfort. The treating physician has documented range of motion was 65 degrees to the left and 35 degrees right rotation. The treating physician has not documented physical exam findings indicative of nerve compromise such as a positive Sturling's test or deficits in dermatomal sensation, reflexes or muscle strength nor positive provocative neurologic exam tests. The criteria not having been met, the requested EMG for the upper extremity is not medically necessary.

Functional capacity evaluation: 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 the American College of Occupational and Environmental Medicine's (ACOEM) Practice Guidelines, 2nd, Edition (2004) Chapter 7, pages 137 and 138.

Decision rationale: The requested Functional capacity evaluation is not medically necessary. CA MTUS The American College of Occupational and Environmental Medicine's Occupational Medicine (ACOEM) Practice Guidelines, 2nd Edition (2004) Chapter 7, page 137-138 note in regards to functional capacity evaluations, that "There is little scientific evidence confirming FCEs predict an individual's actual capacity to perform in the workplace." The injured worker has cervical discomfort. The treating physician has documented range

of motion was 65 degrees to the left and 35 degrees right rotation. There is no documentation that the patient is at Maximum Medical Improvement. The treating physician has not documented the medical necessity for this evaluation as an outlier to referenced guideline negative recommendations. The criteria not having been met, the requested Functional capacity evaluation is not medically necessary.

Massage; manual therapy; Iontophoresis: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy and physical medicine.

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

Decision rationale: The requested Massage; manual therapy; Iontophoresis, is not medically necessary. CA Medical Treatment Utilization Schedule (MTUS) 2009: Chronic Pain Treatment Guidelines, Massage therapy, recommends massage therapy as an option and "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." The injured worker has cervical discomfort. The treating physician has documented range of motion was 65 degrees to the left and 35 degrees right rotation. The treating physician has not documented the injured worker's participation in a dynamic home exercise program or other programs involving aerobic and strengthening exercise. The criteria not having been met, the requested Massage; manual therapy; Iontophoresis is not medically necessary.

Physical therapy 2 x 4 for the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The requested Physical therapy 2 x 4 for the cervical spine is not medically necessary. CA MTUS 2009, Chronic Pain Medical Treatment Guidelines, Physical Medicine, Page 98-99, recommend continued physical therapy with documented objective evidence of derived functional improvement. The injured worker has cervical discomfort. The treating physician has documented range of motion was 65 degrees to the left and 35 degrees right rotation. The treating physician has not documented objective evidence of derived functional improvement from completed physical therapy sessions, nor the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program, nor the medical necessity for a current trial of physical therapy beyond a guideline recommended trial of six sessions and then re-evaluation. The criteria not having been met, the requested Physical therapy 2 x 4 for the cervical spine is not medically necessary.

Physical therapy 2 x 4 for the bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The requested Physical therapy 2 x 4 for the bilateral shoulders is not medically necessary. CA MTUS 2009, Chronic Pain Medical Treatment Guidelines, Physical Medicine, Page 98-99, recommend continued physical therapy with documented objective evidence of derived functional improvement. The injured worker has cervical discomfort. The treating physician has documented range of motion was 65 degrees to the left and 35 degrees right rotation. The treating physician has not documented objective evidence of derived functional improvement from completed physical therapy sessions, nor the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program, nor the medical necessity for a current trial of physical therapy beyond a guideline recommended trial of six sessions and then re-evaluation. The criteria not having been met, the requested Physical therapy 2 x 4 for the bilateral shoulders is not medically necessary.