

<b>Case Number:</b>	CM15-0169448		
<b>Date Assigned:</b>	09/10/2015	<b>Date of Injury:</b>	02/05/2014
<b>Decision Date:</b>	10/14/2015	<b>UR Denial Date:</b>	08/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2015

### 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: 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 43 year old male, who sustained an industrial injury on 2-05-2014. The injured worker was diagnosed as having post-traumatic cephalgia secondary to stress-anxiety, cervical sprain-strain with radiculitis, right, thoracic sprain-strain, lumbar sprain-strain with radiculitis, right, chronic sprain-strain of the right shoulder with tear to labrum and rotator cuff (per magnetic resonance imaging), right lateral epicondylitis, right De Quervain's tenosynovitis, rule out right carpal tunnel syndrome, status post right knee arthroscopy, rule out right knee internal derangement, and chest wall contusion. A history of type 2 diabetes was noted. Treatment to date has included diagnostics, epidural injection, acupuncture, chiropractic, physiotherapy, mental health, and medications. Currently (6-15-2015), the injured worker complains of persistent pain in his right shoulder and low back, with radiation to the lower extremities, right greater than left. It was documented that he had a cervical epidural injection one month prior, which provided him benefit. He also reported occasional pain in his posterior neck. Activities like bending, standing, and walking for prolonged period's aggravated pain. He reported that prescribed medications and use of an interferential 4 unit at home provided relief of his symptoms. It was documented that he received 7 sessions of physiotherapy, 3 chiropractic sessions, and 5 sessions of acupuncture to date. Magnetic resonance imaging of the right knee (4-08-2015) was documented to show tricompartmental osteoarthritic changes, quadriceps tendinitis, patellar tendinitis, and increased signal intensity posterior horn of the medial meniscus, tear could not be excluded. Exam of the cervical and thoracic spines was unremarkable. Exam of the lumbosacral spine noted tenderness to palpation over the bilateral

paralumbar muscles, right gluteus muscles, and spinous processes. Flexion was 50 degrees, extension 15, and lateral bending 15. His right shoulder showed tenderness to palpation at the acromioclavicular joint and bicipital groove, along with positive Hawkin's and Neer's tests. There was tenderness to palpation over the bilateral wrists, right greater than left. Tinel's was questionable bilaterally and Finkelstein's was positive on the right. Cozen's test was positive in the right elbow. Exam of the right knee noted a healed incision over the patella, extension -5 degrees and flexion 130 degrees. McMurray's was questionable positive and there was instability noted. He remained off work. The treatment plan included an orthopedic consult (evaluation right shoulder), chiropractic (1x4), and an IF (interferential) unit for pain symptoms. A subsequent pain management note (7-01-2015) noted increased pain levels and temporary help from a transcutaneous electrical nerve stimulation unit, and a recommendation for a second epidural steroid injection.

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

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

**Chiropractic, once a week for four weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The patient presents on 07/01/15 with pain in the neck and lower back rated 8/10 without medications, 5-6/10 with medications. The patient's date of injury is 02/05/14. Patient is status post right knee arthroscopic surgery at a date unspecified. The request is for Chiropractic, once a week for four weeks. The RFA is dated 06/15/15. Physical examination dated 07/01/15 reveals tenderness to palpation of the right shoulder and right supraspinatus, positive Tinel's and Phalen's signs in the right wrist, decreased sensation along the C6, C7, and C8 dermatomes in the right upper extremity. The provider also notes moderate paraspinal tenderness in the cervical region, positive distraction, Spurling's, and foraminal compression tests on the left. There are also motor deficits noted in the right upper extremity corresponding with the T1 myotome. The patient's full current medication regimen is not provided, though he is noted to be taking Ibuprofen. Per 06/15/15 progress note, patient is advised to remain off work until 07/27/15. MTUS Guidelines, Manual Therapy and Manipulation section, page 40 states: Recommended for chronic pain if caused by musculoskeletal conditions and manipulation is specifically recommended as an option for acute conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in function that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range of-motion but not beyond the anatomic range-of-motion. Treatment Parameters from state guidelines a. Time to produce objective functional gains: 3-5 treatments b. Frequency: 1-5 supervised treatments per week the first 2 weeks, decreasing to 1-3 times per week for the next 6 weeks, then 1-2 times per week for the next 4 weeks, if necessary. c. Optimum duration: Treatment beyond 3-6 visits

should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session. In regard to the 4 sessions of chiropractic manipulation for this patient's chronic pain complaints, the requesting physician has not provided documentation of functional improvements attributed to prior treatments. MTUS guidelines indicate that 3-6 sessions of chiropractic therapy are appropriate for conditions of this nature, and that additional sessions are contingent upon functional benefits. In this case, it is noted that the patient has completed 3 chiropractic therapy treatments to date, however the provider does not document any functional improvements or decreased pain attributed to these visits. Without documentation of symptomatic or measurable functional improvements attributed to previous chiropractic treatments, the request for additional sessions cannot be substantiated. The request is not medically necessary.

**IF4 unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** The patient presents on 07/01/15 with pain in the neck and lower back rated 8/10 without medications, 5-6/10 with medications. The patient's date of injury is 02/05/14. Patient is status post right knee arthroscopic surgery at a date unspecified. The request is for IF 4 unit. The RFA is dated 06/15/15. Physical examination dated 07/01/15 reveals tenderness to palpation of the right shoulder and right supraspinatus, positive Tinel's and Phalen's signs in the right wrist, decreased sensation along the C6, C7, and C8 dermatomes in the right upper extremity. The provider also notes moderate paraspinal tenderness in the cervical region, positive distraction, Spurling's, and foraminal compression tests on the left. There are also motor deficits noted in the right upper extremity corresponding with the T1 myotome. The patient's full current medication regimen is not provided, though he is noted to be taking Ibuprofen. Per 06/15/15 progress note, patient is advised to remain off work until 07/27/15. MTUS Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy section, pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person." In regard to the purchase of an IF unit for this

patient's continuing neck, shoulder, and lower back pain, evidence of a successful 30 day trial has not been provided. Per progress note dated 06/15/15, it is noted that this patient has been using the IF4 unit at home with benefits, though it is not clear if this is part of a 30-day trial of the requested unit or a one-time rental. Were the request for a 30 day rental or trial the recommendation would be for approval. However, the purchase of an IF unit without clear evidence of a successful 30 day trial does not meet MTUS guideline procedures and cannot be substantiated. Therefore, the request is not medically necessary.

**Orthopedic Consult:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7- Independent Medical Examinations and Consultations page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, chapter 7, page 127.

**Decision rationale:** The patient presents on 07/01/15 with pain in the neck and lower back rated 8/10 without medications, 5-6/10 with medications. The patient's date of injury is 02/05/14. Patient is status post right knee arthroscopic surgery at a date unspecified. The request is for orthopedic consult. The RFA is dated 06/15/15. Physical examination dated 07/01/15 reveals tenderness to palpation of the right shoulder and right supraspinatus, positive Tinel's and Phalen's signs in the right wrist, decreased sensation along the C6, C7, and C8 dermatomes in the right upper extremity. The provider also notes moderate paraspinal tenderness in the cervical region, positive distraction, Spurling's, and foraminal compression tests on the left. There are also motor deficits noted in the right upper extremity corresponding with the T1 myotome. The patient's full current medication regimen is not provided, though he is noted to be taking Ibuprofen. Per 06/15/15 progress note, patient is advised to remain off work until 07/27/15. MTUS/ACOEM Guidelines, chapter 7, page 127 states that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. MTUS Guidelines, Pain Outcomes and End Points section, page 8, has the following: "The physician treating in the workers' compensation system must be aware that just because an injured worker has reached a permanent and stationary status or maximal medical improvement does not mean that they are no longer entitled to future medical care." In regard to the ongoing consultation with an orthopedic specialist for this patient's cervical spine, lumbar spine, and shoulder complaint, the request is appropriate. This patient presents with continuing disability and pain in his right shoulder, lower back, and cervical spine secondary to industrial motor vehicle accident. ACOEM and MTUS guidelines indicate that such consultations are supported by guidelines at the care provider's discretion. Therefore, the request is medically necessary.