

Case Number:	CM15-0051098		
Date Assigned:	04/15/2015	Date of Injury:	09/10/2013
Decision Date:	06/02/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/18/2015

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, 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 58-year-old male, with a reported date of injury of 09/10/2013. The mechanism of injury was pulling resulting in a shoulder injury. The diagnoses include cervical spine pain, cervical intervertebral disc disorder syndrome, cervical radiculopathy, status post right shoulder surgery with residual pain, thoracic sprain/strain, and right shoulder sprain/strain. Treatments to date have included an x-ray of the thoracic spine, an x-ray of the right shoulder, physical therapy, oral medications, and an MRI of the right shoulder. Additionally, it was noted that the injured worker was certified for 6 sessions on chiropractic treatment. His diagnostic studies included an official x-ray of the thoracic spine performed on 01/14/2015 which is noted to reveal strengthening of the normal thoracic kyphosis is seen which may reflect an element of myospasm; degenerative anterior superior and anterior inferior endplate. Osteophytes are seen off a few upper thoracic vertebrae. An official x-ray of the right shoulder performed on 01/14/2015, which was noted to reveal degenerative osteophytes are seen of the opposing surfaces of the distal clavicle and the acromion; smooth calcification is seen projecting over the clavicle, which may reflect dystrophic calcification versus artifact. Correlate with clinical and visual inspection. The progress report dated 01/16/2015 indicates that the injured worker complained of neck pain, mid upper back pain, and right shoulder pain. It was noted that the shoulder felt worse in recent weeks for unknown reasons. The objective findings include pain at the cervical spinous processes of C1-C3; pain to palpation of the bilateral suboccipital and bilateral paraspinals; decreased cervical range of motion; positive right shoulder decompression test; pain at the spinous processes of T2-5; pain to palpation of the bilateral thoracic paravertebral and bilateral rhomboid muscles; pain/swelling at the right supraspinous, and trapezius muscles; decreased right shoulder range of motion; and positive right impingement test. The treating physician requested chiropractic

treatment to the cervical/thoracic/right shoulder; acupuncture; interferential (IF) unit purchase; functional capacity evaluation; x-rays of the cervical/thoracic/right shoulder; and an MRI of the right shoulder. A Request for Authorization was submitted on 01/16/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment 2 times a week for 6 weeks to Cervical Thoracic right shoulder:
Upheld

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

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

Decision rationale: The California MTUS Guidelines recommend chiropractic treatment for chronic pain if caused by musculoskeletal conditions. The guidelines recommend 4 to 6 treatments of chiropractic treatment in order to produce effect. With evidence of significant objective functional improvement, the guidelines recommend continued chiropractic treatment at a frequency of 1 to 2 times per week the first 2 weeks and thereafter, treatment may continue at 1 treatment per week for the next 6 weeks. The guidelines recommend treatment may continue for a maximum duration of 8 weeks; however, care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain, and improving quality of life. According to the clinical documentation submitted for review, it was noted that the injured worker was certified for 6 sessions of chiropractic treatment. However, it is unclear whether the injured worker participated in chiropractic treatment and whether the injured worker had significant objective functional improvement within the previous chiropractic treatment. Additionally, there was a lack of significant objective functional deficits of the cervical and thoracic spine. Furthermore, there were no exceptional factors to warrant additional visits beyond the guidelines recommendation. Given the above information, the request is not supported by the guidelines. As such, the request is not medically necessary.

Acupuncture 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California MTUS Guidelines recommend acupuncture as an option when pain medication is reduced or not tolerated and may be used as an adjunct to physical rehabilitation and/or surgical intervention. Acupuncture can be used to reduce pain, reduce

inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The guidelines recommend 3 to 6 treatments in order to demonstrate the efficacy of the therapy with an optimum duration of 1 to 2 months at a frequency of 1 to 3 times per week. The documentation does not clearly indicate if the injured worker has reduced intake of his pain medications or is not tolerating medications. Furthermore, it is not clear if the injured worker will be using acupuncture in adjunct to physical rehabilitation program. Additionally, the request as submitted does not specify a specific body part for the acupuncture treatment. Given the above information, the request is not supported by the guidelines. As such, the request is not medically necessary.

X-rays Cervical/Thoracic/right shoulder: 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, Chapter 9 Shoulder Complaints Page(s): 177-179, 207-209.

Decision rationale: The California MTUS/ACOEM Guidelines state for most patients presenting with true neck or upper back problems and shoulder problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. The clinical documentation submitted for review does not provide evidence that the injured worker has participated in a recent attempt at physical therapy. Additionally, there was no evidence of red flag conditions. Furthermore, there was no evidence of a significant change in the injured worker's physical presentation to warrant a repeat thoracic and right shoulder x-ray. Given the above information, the request is not supported by the guidelines. As such, the request is not medically necessary.

MRI right shoulder: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

Decision rationale: The Official Disability Guidelines state repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The clinical documentation submitted for review does not provided evidence that the injured worker has had a recent attempt at physical therapy. Additionally, there was no evidence of a significant change in the injured worker's physical presentation to warrant a repeat MRI of the shoulder. Given the above information, the request is not supported by the guidelines. As such, the request is not medically necessary.

IF Unit purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: The California MTUS Guidelines state Interferential Units are not recommended as an isolated intervention and there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The clinical documentation submitted for review does not provide evidence that the injured worker is participating in physical therapy. Additionally, the provider failed to specify the body area for use with the unit. Furthermore, it was unclear if the injured worker has undergone a 1-month trial with the unit and its efficacy. Given the above information, the request is not supported by the guidelines. As such, the request is not medically necessary.

Functional Capacity Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), page 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for duty, Functional capacity evaluation (FCE).

Decision rationale: The California MTUS/ACOEM Guidelines recommend considering using a functional capacity evaluation when it is necessary to decipher medical impairment into functional boundaries and define work capability. The Official Disability Guidelines recommend performing a functional capacity evaluation prior to admission to a work hardening program. The guidelines recommend considering a Functional Capacity Evaluation if case management is hampered by complex issues including prior unsuccessful return to work attempts, when there is conflicting medical reporting on precautions and/or fitness for modified job, or if there are injuries that require detailed exploration of a worker's abilities. The guidelines recommend a Functional Capacity Evaluation if patients are close to or at maximum medical improvement and all key medical reports are secured and if additional/ secondary conditions are clarified. Within the documentation provided, there is no rationale indicating why the physician is requesting Functional Capacity Evaluation. Additionally, there is no indication if the request is for a work hardening program or if the injured worker is at maximum medical improvement. In the absence of this documentation, the request is not supported by the guidelines. As such, the request is not medically necessary.