

Case Number:	CM14-0172300		
Date Assigned:	10/23/2014	Date of Injury:	01/14/2008
Decision Date:	11/21/2014	UR Denial Date:	09/18/2014
Priority:	Standard	Application Received:	10/17/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 61-year-old male with a 1/14/08 date of injury. At the time (9/10/14) of request for authorization for Chiropractic care to the neck, 1 x 6, Cervical spine MRI, and Replacement of supplies for Interferential Unit, with conversion of rental to purchase, there is documentation of subjective (mild to severe left shoulder pain increasing with movement; and increasing intermittent moderate to severe neck pain occurring daily with headaches and associated right upper extremity radiculopathy (C5)) and objective (left shoulder tenderness to palpation with limited range of motion and weakness in all planes; tenderness to palpation over the cervical spine paravertebral muscles, trapezius, and suboccipital muscle with spasms and decreased range of motion, positive Spurling's test, and decreased sensation in the right C5 dermatome) findings, current diagnoses (cervical spine sprain/strain with bilateral upper extremity radiculopathy; and left shoulder degenerative joint disease, tendinitis, and biceps tenosynovitis), and treatment to date (physical therapy, medications (including opioids, NSAIDS, and Zanaflex with decreased pain levels and improved sleep patterns); ongoing interferential unit therapy with increased ability to perform home exercise program and activities of daily living; and home exercise program). Medical report identifies a request for a short course of chiropractic treatment to address recent flare-up of neck pain; continue home interferential unit, home exercise program, and medications; and MRI of the cervical spine to assess for progression of positive discogenic findings on prior study (3 years ago) given recent significant increase in pain/symptoms with positive clinical findings. In addition, medical reports identify a previous MRI of the cervical spine performed on 9/2/11 and previous chiropractic treatment (unknown amount). Regarding Chiropractic care to the neck, 1 x 6, there is no documentation of the number of previous chiropractic therapy treatments; treatment success with return to work achieved with previous chiropractic treatment; and positive

symptomatic or objective measurable gains in functional improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of chiropractic therapy provided to date. Regarding Replacement of supplies for Interferential Unit, with conversion of rental to purchase, there is no documentation of additional recommended treatments, including return to work, and limited evidence of improvement on recommended treatments alone.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic care to the neck, 1 x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & manipulation Page(s): 58. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that manual therapy/manipulation is recommended for chronic pain if caused by musculoskeletal conditions, and that the intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. MTUS additionally supports a trial of 6 visits, with evidence of objective functional improvement, a total of up to 18 visits over 6-8 weeks. Furthermore, MTUS necessitates documentation of treatment success with previous chiropractic treatment, and if return to work achieved then 1-2 visits every 4-6 months, as criteria necessary to support the medical necessity of chiropractic treatment for recurrences/flare-ups. Within the medical information available for review, there is documentation of diagnoses of cervical spine sprain/strain with bilateral upper extremity radiculopathy; and left shoulder degenerative joint disease, tendinitis, and biceps tenosynovitis. In addition, there is documentation of a request for a short course of chiropractic treatment to address recent flare-up of neck pain. However, there is no documentation of the number of previous chiropractic therapy treatments; and treatment success with return to work achieved with previous chiropractic treatment. In addition, there is no documentation of positive symptomatic or objective measurable gains in functional improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of chiropractic therapy provided to date. Furthermore, the proposed number of sessions exceeds chiropractic guidelines (for recurrences/flare-ups). Therefore, based on guidelines and a review of the evidence, the request for chiropractic care to the neck, 1 x 6 is not medically necessary.

Cervical spine MRI: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-183. Decision based on Non-MTUS Citation Other Medical Treatment Guidelines: Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative, physiologic evidence (in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans) of tissue insult or neurologic dysfunction, failure of conservative treatment; or diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure; as criteria necessary to support the medical necessity of an MRI. ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of diagnoses of cervical spine sprain/strain with bilateral upper extremity radiculopathy; and left shoulder degenerative joint disease, tendinitis, and biceps tenosynovitis. In addition, there is documentation of a previous cervical MRI performed on 9/2/11. Furthermore, given documentation of subjective (increasing intermittent moderate to severe neck pain occurring daily with headaches and associated right upper extremity radiculopathy (C5)) and objective (tenderness to palpation over the cervical spine paravertebral muscles, trapezius, and suboccipital muscle with spasms and decreased range of motion, positive Spurling's test, and decreased sensation in the right C5 dermatome) findings, and a request for MRI of the cervical spine to assess for progression of positive discogenic findings on prior study (3 years ago) given recent significant increase in pain/symptoms with positive clinical findings, there is documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for cervical spine MRI is medically necessary.

Replacement of supplies for Interferential Unit, with conversion of rental to purchase:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that interferential current stimulation is not recommended as an isolated intervention and that 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. Within the medical information available for review, there is documentation of diagnoses of cervical spine sprain/strain with bilateral upper extremity radiculopathy; and left shoulder degenerative joint disease, tendinitis, and biceps tenosynovitis. In addition, there is documentation of ongoing interferential unit treatment with increased ability to perform home exercise program and activities of daily living. Furthermore, there is documentation that the IF unit will be used in conjunction with recommended treatments, including exercise and medications. However, there is no documentation of additional recommended treatments, including return to work. In addition, given documentation of ongoing treatment with medications (including opioids, NSAIDS, and Zanaflex) with decreased pain levels and improved sleep patterns, there is no documentation of limited evidence of improvement on recommended treatments alone. Furthermore, the proposed duration (conversion of rental to purchase) exceeds guidelines. Therefore, based on guidelines and a review of the evidence, the request for Replacement of supplies for Interferential Unit, with conversion of rental to purchase is not medically necessary.