

Case Number:	CM15-0149910		
Date Assigned:	08/17/2015	Date of Injury:	06/11/2012
Decision Date:	10/08/2015	UR Denial Date:	07/14/2015
Priority:	Standard	Application Received:	08/03/2015

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 66 year old male who sustained an industrial injury on 6-11-2012. He was lifting and carrying objects while at work. He reports injury to the neck, knees, wrist, hands, shoulder, and back from repetitive movements while operating machines. His current complaints involved the neck, bilateral shoulders, bilateral hands-wrist, and lower back. Diagnosis include cervical spine sprain strain, myofasciitis, cervical spine facet induced versus discogenic pain, lumbar spine sprain strain and facet induced versus discogenic pain, lumbar spine herniations, rule out, bilateral shoulder tenosynovitis, bursitis, rule out rotator cuff tear, bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome, and bilateral knee internal derangement. Treatment has included conservative methods. There was tenderness to the cervical spine. Range of motion was decreased with pain. There was a positive Tinel's sign and positive Phalen's. Range of motion to the wrists was normal. There was palpable tenderness to the lumbar spine. Range of motion was limited. The treatment plan included chiropractic care, x-rays, and MRI. The treatment request included electrical stimulation and massage therapy, extracorporeal shock therapy, chiropractic care, MRI of the cervical spine, upper extremity EMG/NCV, MRI of bilateral shoulders, cervical pillow, lumbar support, acupuncture, and MRI of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic follow up visits 2x week for 4 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 request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal 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 functional improvement 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. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case, the patient would benefit most from at home active therapy. As such, the request is not medically necessary.

Electrical stimulation 2x week for 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care.

Decision rationale: The request is for TENS unit use to aid in pain relief. The MTUS guidelines state the following regarding this topic: "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and return of patients to activities of normal daily living." In this case, the request is not indicated. This is secondary to poor high-grade evidence to support its use. As such, the request is not medically necessary.

Massage therapy 2x week for 4 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 request is for massage therapy. The MTUS guidelines state the following regarding this topic: 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. Scientific studies show contradictory results. Furthermore, many studies lack long-term followup. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided. This lack of long-term benefits could be due to the short treatment period or treatments such as these do not address the underlying causes of pain. (Hasson, 2004) A very small pilot study showed that massage can be at least as effective as standard medical care in chronic pain syndromes. Relative changes are equal, but tend to last longer and to generalize more into psychologic domains. (Walach 2003) The strongest evidence for benefits of massage is for stress and anxiety reduction, although research for pain control and management of other symptoms, including pain, is promising. The physician should feel comfortable discussing massage therapy with patients and be able to refer patients to a qualified massage therapist as appropriate. (Corbin 2005) Massage is an effective adjunct treatment to relieve acute postoperative pain in patients who had major surgery, according to the results of a randomized controlled trial recently published in the Archives of Surgery. (Mitchinson, 2007) In this case, the request is not supported by the guidelines. This is secondary to the number of treatments requested which is beyond the 4-5 maximum limit. As such, the request is not medically necessary.

Extracorporeal shock therapy 2x week for 4 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- Extracorporeal shock wave therapy (ESWT).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic (Acute & Chronic)/Extracorporeal shock wave therapy (ESWT).

Decision rationale: The request is for Extracorporeal shock wave therapy (ESWT). The MTUS guidelines has limited information regarding this topic for back pain. The Official Disability Guidelines state the following: Not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. (Seco, 2011) In this case, the use of this treatment modality is not indicated. This is secondary to poor clinical evidence regarding effectiveness of use. As such, the request is not medically necessary.

EMG/NCV Bilateral Upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation ODG- EMG and NCV.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back/Nerve conduction studies.

Decision rationale: The request is for nerve conduction studies. The MTUS guidelines are silent regarding this issue. The ODG states the following: Not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) (Lin, 2013) While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. (Emad, 2010) (Plastaras, 2011) (Lo, 2011) (Fuglsang-Frederiksen, 2011) See also the Shoulder Chapter, where nerve conduction studies are recommended for the diagnosis of TOS (thoracic outlet syndrome). Also see the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. In this case, the use of this diagnostic test is not supported. This is secondary to poor documentation of peripheral nerve compromise necessitating further clarity. There is also inadequate discussion of how the result of this study would change the clinical management. Pending receipt of this information, the request is not medically necessary.

Chiropractic adjustments 2x week for 4 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 request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal 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 functional improvement 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. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case,

the patient would benefit most from at home active therapy. As such, the request is not medically necessary.

Acupuncture x13 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007, and Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care.

Decision rationale: The request is for acupuncture to aid in pain relief. The ACOEM guidelines state the following regarding this topic. "Invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints, 2 or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms." In this case the guidelines do not support the use of this treatment modality. This is secondary to the diagnosis with poor clinical evidence regarding efficacy. As such, the request is not medically necessary.

MRI cervical spine: 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 Official Disability Guidelines (ODG) Neck and upper back complaints/MRI.

Decision rationale: The request is for an MRI of the thoracic spine. The ACOEM guidelines state that when there is physiological evidence of tissue insult or neurological deficits, consider a discussion with a consultant regarding the next steps including MRI imaging. An imaging study may be appropriate in patients where symptoms have lasted greater than 4-6 weeks and surgery is being considered for a specific anatomic defect or to further evaluate the possibility of serious pathology, such as a tumor. Reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results) because it's possible to identify a finding that was present before symptoms began and, therefore, has no temporal association with the symptoms. The ODG guidelines regarding qualifying factors for an MRI of the neck or upper back are as follows: Indications for imaging -- MRI (magnetic resonance imaging): Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present, Neck pain with radiculopathy if severe or progressive neurologic deficit, Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present, Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present, Chronic neck pain, radiographs show bone or disc margin destruction, Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal", Known cervical spine trauma: equivocal or positive plain films with neurological deficit, Upper back/thoracic spine trauma

with neurological deficit. In this case, there is inadequate documentation in a change in neurologic status seen on exam. The records do not indicate new "red flags" which would warrant further imaging evaluation. Pending further information regarding new neurologic deficits, the request is not medically necessary.

MRI Bilateral shoulders: 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 Official Disability Guidelines (ODG) Shoulder (Acute & Chronic)/MRI.

Decision rationale: The request is for an MRI of the shoulder. The Official Disability Guidelines state the following regarding the qualifying indications: Indications for imaging -- Magnetic resonance imaging (MRI): Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs, Subacute shoulder pain, suspect instability/labral tear, Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008) In this case, this study is not indicated. This is secondary to inadequate documentation of qualifying indications as listed above. As such, the request is not medically necessary.

Cervical pillow: 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 Official Disability Guidelines (ODG) Neck and upper back (acute & chronic)/pillow.

Decision rationale: The request is for a cervical pillow. The MTUS guidelines are silent regarding this topic. The Official Disability Guidelines state the following: Recommend use of a neck support pillow while sleeping, in conjunction with daily exercise. This RCT concluded that subjects with chronic neck pain should be treated by health professionals trained to teach both exercises and the appropriate use of a neck support pillow during sleep; either strategy alone did not give the desired clinical benefit. (Helewa, 2007) In this case, the use of a special neck pillow is not indicated. This is secondary to inadequate documentation stating the need for a specialized neck support. A regular supportive pillow should be adequate for this function. As such, the request is not medically necessary.

Lumbar support: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Prevention.

Decision rationale: The request is for the use of a lumbar back support to aid in pain relief and injury prevention. The ACOEM guidelines makes the following statement: "The use of back belts as lumbar support should be avoided because they have been shown to have little or no benefit, thereby providing only a false sense of security." As an alternative it is advised that prolonged sitting and standing should be reduced by providing rest and exercise breaks and task rotation and variation should be employed. Heavy loads need to be divided and mechanical support devices used. Also, the workstation can be set up to optimize reduction in back strain. As such, due to poor evidence of its utility and effectiveness, the request is not medically necessary.

MRI Lumbar spine: 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 Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic)/ MRIs (magnetic resonance imaging).

Decision rationale: The request is for an MRI of the lumbar spine. The ODG guidelines state the following regarding qualifying criteria: Indications for imaging -- Magnetic resonance imaging: Thoracic spine trauma: with neurological deficit, Lumbar spine trauma: trauma, neurological deficit, Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit), Uncomplicated low back pain, suspicion of cancer, infection, other "red flags", Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. Uncomplicated low back pain, prior lumbar surgery, Uncomplicated low back pain, cauda equina syndrome-Myelopathy (neurological deficit related to the spinal cord), traumatic-Myelopathy, painful-Myelopathy, sudden onset-Myelopathy, stepwise progressive-Myelopathy, slowly progressive-Myelopathy, infectious disease patient-Myelopathy, oncology patient-Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). In this case, an MRI is not advised. This is secondary to a lack of a change in clinical status or described "red flags." Pending further information revealing qualifying indications as listed above, the request is not medically necessary.