

Case Number:	CM15-0044685		
Date Assigned:	04/13/2015	Date of Injury:	07/17/2014
Decision Date:	05/26/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	03/10/2015

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, Florida, Illinois
 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 reported an injury on 07/17/2014 due to an unspecified mechanism of injury. On 03/05/2015, she presented for an evaluation of her work related injury. She complained of occasional severe pain in the cervical spine aggravated by turning her head, constant thoracic spine pain that was moderate in nature and described as burning and aching and aggravated by sitting or standing, occasional moderate pain in the lumbar spine described as soreness on palpation, pain in the bilateral shoulders that was frequent but minimal and increased with reaching. She also reported difficulty sleeping because of her pain. On examination, there was +2 spasm and tenderness to the bilateral paraspinals from C2-7, bilateral suboccipital muscle, and bilateral upper muscles in the shoulders. The decompression test was positive on the left and the left triceps reflex was decreased. The right triceps reflex was also decreased. There was +1 spasm and tenderness to the bilateral paraspinal muscles from T2-8 and the lumbar spine showed +3 spasm and tenderness to bilateral lumbar paraspinal muscles from L1-S1 and multifidus. Kemp's test was positive bilaterally, Yeoman's was positive bilaterally, and Braggard's was negative. The right patellar reflex was decreased. Examination of the shoulders showed +3 spasm and tenderness to the left upper shoulder muscles and left rotator cuff muscles. There was a trigger point to the right upper shoulder muscles and right shoulder rotator cuff muscles. Speed's test was positive on the right and supraspinatus test was positive on the right. She was diagnosed with a lumbar disc herniation without nerve compression, cervical disc herniation without nerve compression, thoracic disc herniation without nerve compression, and rotator cuff sprain and strain. It was noted that the injured

worker has previously completed 12 sessions of acupuncture therapy. Treatment plan was for acupuncture, electroacupuncture, manual therapy, electrical stimulation, infrared, diathermy, and a followup visit to assess range of motion measurements.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture 3 x 2 for the cervical/thoracic/lumbar spine and bilateral shoulders: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated and it is recommended as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. 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 time to produce functional improvement is 3 to 6 treatments and acupuncture treatments may be extended if functional improvement is documented including either a clinically significant improvement in activities of daily living or a reduction in work restrictions. The documentation provided indicates the injured worker had already attended acupuncture therapy. However, her response to treatment was not clearly documented. There was no indication that she had a quantitative decrease in pain or an objective improvement in function with acupuncture therapy to support the request. Therefore, the request is not supported. As such, the request is not medically necessary.

Electroacupuncture 3 x 2 for the cervical/thoracic/lumbar spine and bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California MTUS guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated and it is recommended as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. 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. Acupuncture with electrical stimulation is the use of electrical current on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. The time to produce functional improvement is 3 to 6 treatments and Acupuncture treatments may be extended if functional improvement is documented including either a clinically significant improvement in activities of daily living or a

reduction in work restrictions. The documentation provided indicates the injured worker had already attended acupuncture therapy. However, her response to treatment was not clearly documented. There was no indication that she had a quantitative decrease in pain or an objective improvement in function with acupuncture therapy to support the request. Therefore, the request is not supported. As such, the request is not medically necessary.

Manual therapy 3 x 2 for the cervical/thoracic/lumbar spine and bilateral shoulders:

Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58, 59.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement a total of up to 18 visits over 6-8 weeks may be appropriate. Treatment for flare-ups requires a need for re-evaluation of prior treatment success. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Treatment beyond 4-6 visits should be documented with objective improvement in function. The maximum duration is 8 weeks and at 8 weeks patients should be re-evaluated. 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. Further clarification is needed regarding the injured worker's prior treatments and whether or not female has undergone manual therapy previously to address the same injury. Also, there is a lack of documentation showing that has any significant functional deficits to support the medical necessity of this request. Therefore, the request is not supported. As such, the request is not medically necessary.

E-stimulation 3 x 2 for the cervical/thoracic/lumbar spine and bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Electrical Stimulators (e-stim) Page(s): 45.

Decision rationale: The CAMTUS Guidelines indicate that Electrical stimulators (E-stim) come in various forms and all have different criteria for use. The documentation provided fails to show what type of electrical stimulation the injured worker would be using. All different types of electrical stimulation have different requirements prior to use. Therefore, without knowing the type of electrical stimulation the injured worker plans to use, the request would not be supported. As such, the request is not medically necessary.

Infrared 3 x 2 for the cervical/thoracic/lumbar spine and bilateral shoulders: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low-Level Laser Therapy (LLLT) Page(s): 57.

Decision rationale: The CAMTUS Guidelines state that this form of treatment is not recommended. Given that this type of treatment is not recommended by the cited guidelines the request would not be supported. Also, there was no clear rationale provided for the medical necessity of this request. Therefore, the request is not supported. As such, the request is not medically necessary.

Diathermy 3 x 2 for the cervical/thoracic/lumbar spine and bilateral shoulders: Upheld

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

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 Chapter, Neck & Upper Back Chapter, Shoulder Chapter, Diathermy.

Decision rationale: The Official Disability Guidelines state that Diathermy is not recommended. Given that this type of treatment is not recommended by the cited guidelines the request would not be supported. Also, there was no clear rationale provided for the medical necessity of this request. Therefore, the request is not supported. As such, the request is not medically necessary.

Follow-up visit with range of motion measurement and addressing ADLs for the cervical/thoracic/lumbar spine and bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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 Chapter, Flexibility.

Decision rationale: The Official Disability Guidelines state that this form of testing is not recommended as a primary criteria, but should be a part of a routine musculoskeletal evaluation. Given that this type of treatment is not recommended by the cited guidelines and no clear indication was stated for its use, the request would not be supported. There was no clear rationale for the medical necessity of specialized range of motion testing and without a clear rationale, the request would not be supported. As such, the request is not medically necessary.