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| <b>Case Number:</b>   | CM15-0093705 |                              |            |
| <b>Date Assigned:</b> | 05/20/2015   | <b>Date of Injury:</b>       | 01/28/2013 |
| <b>Decision Date:</b> | 07/07/2015   | <b>UR Denial Date:</b>       | 04/17/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/14/2015 |

### 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: Florida

Certification(s)/Specialty: Family Practice

### 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 63-year-old female who sustained an industrial injury on January 28, 2013. She has reported injury to the cervical spine, right shoulder, and right wrist and has been diagnosed with cervical disc protrusion, cervicgia, cervicobrachial syndrome, right rotator cuff tear, right shoulder impingement syndrome, right carpal tunnel syndrome. Treatment has included medications, medical imaging, physical therapy, acupuncture, chiropractic care, and injection. Objective findings noted cervical compression caused pain. Foraminal compression causes pain on the right. The right shoulder was noted that supraspinatus pressure caused pain. Shoulder apprehension caused pain. Right wrist noted Phalen's caused pain. Fromeute's paper was positive. The treatment request included an orthopedic consultation, pain management consultation, acupuncture, chiropractic care, and a paraffin wax therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ortho consult:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, page 127 and Official Disability Guidelines, Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines occupational practice medicine guidelines Page(s): 2-3.

**Decision rationale:** The California MTUS guidelines state, "Referral is indicated in cases where the health care provider has a lack of training in managing the specific entity, is uncertain about the diagnosis or treatment plan, or red flags are present. If significant symptoms causing self-limitations or restrictions persist beyond 4-6 weeks, referral for specialty evaluation (e.g., occupational medicine, physical medicine and rehabilitation, or orthopedic surgery) may be indicated to assist in the confirmation of the provisional diagnosis and to define further clinical management." This patient's provider has requested an Orthopedics consultation. This patient has been documented to have substantial orthopedic problems that have been ongoing for much longer than 4-6 weeks. There is no reason in accordance with MTUS guidelines to deny the primary treating physician the ability to refer this patient on for a specialty consultation with an orthopedic physician. Likewise, this request is considered medically necessary.

**Pain management consult:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, page 127 and Official Disability Guidelines, Low Back.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines occupational practice medicine guidelines, page(s) 2-3 Page(s): 2-3.

**Decision rationale:** The California MTUS guidelines state, "Referral is indicated in cases where the health care provider has a lack of training in managing the specific entity, is uncertain about the diagnosis or treatment plan, or red flags are present. If significant symptoms causing self-limitations or restrictions persist beyond 4-6 weeks, referral for specialty evaluation (e.g., occupational medicine, physical medicine and rehabilitation, or orthopedic surgery) may be indicated to assist in the confirmation of the provisional diagnosis and to define further clinical management." This patient's provider has requested a Pain management consultation. This is a patient, who has had substantial orthopedic injuries for much longer than 4-6 weeks, and the primary treating physician has attempted multiple conservative treatment measures and yet the patient still has ongoing pain. A pain management consultation appears appropriate. Likewise, this request is considered medically necessary.

**Acupuncture 2x6 right shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Acupuncture Medical Treatment Guidelines Page(s): 8-11.

**Decision rationale:** In accordance with California MTUS Acupuncture guidelines "(c) Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(ef)." Section 9792.20 e and f are defined as follows, "(e) "Evidence-based" means based, at a minimum, on a systematic review of literature published in medical journals included in MEDLINE." "(f) "Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment." Regarding this patient's case, it is documented that she has previously had acupuncture therapy; however, the number of prior treatments nor functional benefits gained/not gained are not discussed. Likewise, without additional documentation this request for additional acupuncture cannot be determined to be medically necessary.

**Chiro therapy 2x6 right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & Manipulation Page(s): 95.

**Decision rationale:** Chiropractic therapy is supported by MTUS guidelines under certain conditions. This patient has previously had chiropractic therapy; however, the exact number of prior treatments and what objective functional improvement occurred is not documented. Before additional chiropractic therapy can be authorized additional information is required per MTUS guidelines. As MTUS, guidelines have not been satisfied with the provided documentation, this request cannot be considered medically necessary. MTUS Guideline referenced: Manual therapy & manipulation. 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. Low back: Recommended as an option. Therapeutic care & Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care & Not medically necessary. Recurrences/flare-ups & Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines: a. Time to produce effect: 4 to 6 treatments; b. Frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for

the next 6 weeks. c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. 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. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 4-6 visits should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session. (Colorado, 2006) Injured workers with complicating factors may need more treatment, if documented by the treating physician. Number of Visits: Several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Active Treatment versus Passive Modalities: Manipulation is a passive treatment, but many chiropractors also perform active treatments, and these recommendations are covered under Physical therapy (PT), as well as Education and Exercise. 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 fewer visits would be required in uncomplicated cases. This request is not medically necessary.

**Paraffin wax therapy 2x6 right hand:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist and Hand Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG 2015 online edition. Paraffin Wax Baths.

**Decision rationale:** MTUS guidelines are silent on Paraffin wax treatments. Therefore, the ODG guidelines were referenced. The ODG states the following: "Recommended as an option for arthritic hands if used as an adjunct to a program of evidence-based conservative care (exercise). According to a Cochrane review, paraffin wax baths combined with exercises can be recommended for beneficial short-term effects for arthritic hands. These conclusions are limited by methodological considerations such as the poor quality of trials. (Robinson-Cochrane, 2002)" Regarding this patient's case, there is no documentation of hand arthritis. There is also no documentation that these baths will be combined with an exercise program. Likewise, this request is not considered medically necessary.