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| Case Number: | CM14-0002310 | | |
| Date Assigned: | 03/03/2014 | Date of Injury: | 02/21/2011 |
| Decision Date: | 06/16/2014 | UR Denial Date: | 12/23/2013 |
| Priority: | Standard | Application Received: | 01/07/2014 |

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 and Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in New York and Texas. 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:

The injured worker is a 42-year-old female whose date of injury is February 21, 2011. The injured worker sustained repetitive use injuries secondary to performing her job duties. The injured worker was diagnosed with anxiety, depressive disorder, disorder of bursae and tendons in shoulder region, enthesopathy of wrist and elbow, and cervical radiculopathy. Initial orthopedic evaluation dated November 6, 2013 indicates that the patient has completed a course of physical therapy for her neck, shoulders, elbows, wrists/hands, and lower back at intervals of three times a week for approximately five to six weeks, providing her temporary pain relief. She was last examined in late 2012 at which time she was advised to resume her regular work duties. The patient is currently working full duty. Medications are listed as Tylenol and Ibuprofen. Diagnoses are listed as cervical radiculopathy, bilateral shoulder tendonitis/bursitis, bilateral elbow tendonitis/bursitis, bilateral wrist tendonitis/bursitis, thoracic sprain/strain, and lumbar spine sprain/strain with coccyx pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

4 SESSIONS OF PSYCHOTHERAPY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BEHAVIORAL INTERVENTIONS Page(s): 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
BEHAVIORAL INTERVENTIONS Page(s): 23.

Decision rationale: Based on the clinical information provided, the request for four sessions of psychotherapy is not recommended as medically necessary. The submitted records fail to establish that the patient has undergone an initial diagnostic interview to establish a working diagnosis and individualized treatment plan for this patient. The request for four sessions of psychotherapy is not medically necessary or appropriate.

ACUPUNCTURE 2 X WEEK FOR 3 WEEKS FOR THE CERVICAL, THORACIC, AND LUMBAR SPINE AND LEFT AN RIGHT ARMS.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Based on the clinical information provided, the request for acupuncture two times a week for three weeks to the cervical, thoracic and lumbar spine and left and right arms is not recommended as medically necessary. There is no current, detailed physical examination submitted for review as the most recent evaluation is from November 2013. The request for acupuncture for the cervical, thoracic, and lumbar spine and left an right arms, twice weekly for three weeks, is not medically necessary or appropriate.

CHIROPRACTIC TREATMENT FOR THE CERVICAL, THORACIC, AND LUMBAR SPINE, TWICE WEEKLY FOR FOUR WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
MANUAL THERAPY AND MANIPULATION Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
MANUAL THERAPY AND MANIPULATION Page(s): 58-60.

Decision rationale: Based on the clinical information provided, the request for chiropractic treatment two times a week for four weeks for the cervical, thoracic and lumbar spine is not recommended as medically necessary. The submitted records indicate that the patient has been authorized for six sessions of chiropractic treatment for the cervical, thoracic and lumbar spine; however, the patient's objective functional response to this treatment is not documented to establish efficacy of treatment and support additional sessions. The request for chiropractic treatment for the cervical, thoracic, and lumbar spine, twice weekly for four weeks, is not medically necessary or appropriate.

CHIROPRACTIC TREATMENT OF THE LEFT AND RIGHT ARMS, TWICE WEEKLY FOR FOUR WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION Page(s): 58-60.

Decision rationale: Based on the clinical information provided, the request for chiropractic treatment of the left and right arms is not recommended as medically necessary. California Medical Treatment Utilization Schedule guidelines do not recommend chiropractic sessions for the treatment of the forearm, wrist and hand. The request for chiropractic treatment of the left and right arms, twice weekly for four weeks, is not medically necessary or appropriate.