

Case Number:	CM14-0007278		
Date Assigned:	02/10/2014	Date of Injury:	12/04/2013
Decision Date:	08/11/2014	UR Denial Date:	01/07/2014
Priority:	Standard	Application Received:	01/20/2014

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 Occupational Medicine 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:

The patient is a 58-year-old male who has submitted a claim for lumbo-sacral strain/sprain with radiculitis, r/o disc herniation, cervical strain/sprain with radiculitis, r/o disc herniation, bilateral shoulder strain/sprain, r/o internal derangement, left medial epicondylitis associated with an industrial injury date of 12/4/2013. The medical records from 2013 were reviewed which revealed persistent low back pain which radiated to the foot. There was neck pain, which radiated to left hand, both shoulders and left elbow. There was poor concentration and memory. He also has difficulty sleeping. The physical examination showed slight decrease in range of motion of left elbow and left shoulder secondary to pain. There was tenderness along the C3-7. The examination of the thoracic spine and lumbosacral spine revealed tenderness along T6-12 and L5-S1. Impingement test was negative on the right shoulder and equivocal on the left. Tinel's sign was negative bilaterally. MMT was 5/5. No sensory deficits noted. An MRI of the cervical spine done on 1/9/14 showed mild congenital narrowing of the spinal canal. There was degenerative disc space narrowing at the level of C5-6 with a 2 mm broad-based posterior osteophyte causing mild to moderate narrowing of the spinal canal. There was mild bilateral neural foraminal narrowing. An MRI of left shoulder done on 1/13/14 showed slight tendinosis of the subscapularis tendon. The treatment to date has included, chiropractic treatments. Medications taken include, Naproxen, Tramadol ER, Omeprazole, Cyclobenzaprine and Topical Analgesics. The request for interferential current stimulation unit was denied. The chiropractic sessions were modified because patient has a diagnosis of shoulder strain and sprain. The guidelines support manipulation as long as benefit is achieved. 2 chiropractic visits with reevaluation was given to determine any benefit. Regarding interferential unit, it was denied because there is no documentation to support the medical necessity of interferential unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC SESSIONS 2 TIMES PER WEEK X 4 WEEKS TO THE LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Chiropractic Guidelines Section, Sprains and Strains of shoulder and upper arm.

Decision rationale: Page 58 of the CA MTUS Chronic Pain Medical Treatment Guidelines recommended manipulation therapy for chronic pain if caused by musculoskeletal conditions. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. In addition, the ODG allows 9 chiropractic sessions over 8 weeks for sprains and strains of shoulder and upper arm. Fading of treatment is recommended to allow self-directed home therapy. In this case, patient was diagnosed to have bilateral shoulder sprain and strain. He started to have chiropractic sessions as stated on his progress report dated 12/26/13. However, the exact number of sessions completed, as well as the response from this treatment was not clearly documented. There was no evidence stating the functional improvements that the patient has gained from previous chiropractic treatment. Therefore, the request for chiropractic sessions 2 times per week for 4 weeks to the left shoulder is not medically necessary.

INTERFERENTIAL CURRENT STIMULATION UNIT (I.F. UNIT): Upheld

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

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

Decision rationale: As stated on pages 118-120 of CA MTUS Chronic Pain Medical Treatment Guidelines, interferential current stimulation is not recommended as an isolated intervention. 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. In addition, guidelines stated that a one-month trial may be appropriate when pain is ineffectively controlled due to diminished effectiveness of medications, exercise programs/physical therapy treatment; or unresponsive to conservative measures. In this case, patient's records did not document if he had significant improvement with chiropractic session. In addition, it is unclear whether the patient has exhausted all conservative treatment measures. Furthermore, the present request did not mention

the duration of use and if its for rental or purchase. Guidelines have not been met. Therefore, the request for interferential current stimulation unit (IF unit) is not medically necessary.