

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0019797 | | |
| Date Assigned: | 04/28/2014 | Date of Injury: | 03/01/2013 |
| Decision Date: | 07/08/2014 | UR Denial Date: | 01/27/2014 |
| Priority: | Standard | Application Received: | 02/18/2014 |

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 Family Practice, and is licensed to practice in Tennessee, California, and Virginia. 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 51 year old male whose date of injury is 3/1/13. He sustained cumulative trauma to his low back and left shoulder due to the repetitive nature of his work. EMG/NCV dated 11/26/13 is reported to be a normal study. A note dated 12/31/13 indicates that the injured worker has been receiving chiropractic treatment for the last 19 weeks. The injured worker states that he has been receiving myofascial release for the last 19 weeks. Progress note dated 3/25/14 indicates that therapy is helpful. He continues to complain of low back pain with occasional radiation to both legs. Left shoulder joint pain increases with activities. Diagnoses are left shoulder sprain/strain, lumbosacral sprain/strain, and lumbago.

IMR ISSUES, DECISIONS AND RATIONALES

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

SIX (6) ELECTRONIC STIMULATION (UNATTENDED) TREATMENTS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114-117.

Decision rationale: The injured worker sustained sprain/strain injuries which should have resolved at this time. There are no specific, time-limited treatment goals provided as required by

the California MTUS guidelines. There is no clear rationale provided to support this passive modality at this point in the injured worker's treatment. As such, the request is not medically necessary.

SIX (6) MYOFASCIAL RELEASE/SOFT TISSUE THERAPY TREATMENTS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Page(s): 146.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MASSAGE THERAPY Page(s): 60.

Decision rationale: The injured worker has completed at least 19 weeks of myofascial release, and the submitted records fail to document significant progress as a result of this treatment. The California MTUS guidelines note that this treatment should be limited to 4-6 treatments in most cases, and there is no clear rationale provided to support continuing to exceed this recommendation. There are no exceptional factors of delayed recovery documented. As such, the request is not medically necessary.

SIX (6) INFRARED THERAPY TREATMENTS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines LOW-LEVEL LASER THERAPY (LLLT) Page(s): 57.

Decision rationale: The California MTUS guidelines do not support infrared therapy treatment as there is insufficient literature at this time to establish efficacy of treatment. As such, the request is not medically necessary.

SIX (6) CHIROPRACTIC MANIPULATIVE THERAPY TREATMENTS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION.

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

Decision rationale: The injured worker has completed at least 19 weeks of chiropractic treatment, and the submitted records fail to document significant improvement. The California MTUS guidelines would support 1-2 visits every 4-6 months for a recurrence or flare-up and note that elective/maintenance care is not medically necessary. The patient has completed sufficient chiropractic treatment and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. As such, the request is not medically necessary.

THREE (3) SHOCKWAVE THERAPY TREATMENTS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: The injured worker's diagnosis is left shoulder sprain/strain. The Official Disability Guidelines support extracorporeal shock wave therapy for the treatment of calcifying tendonitis, but not for other shoulder disorders. As such, the request is not medically necessary.