

Case Number:	CM14-0116893		
Date Assigned:	08/04/2014	Date of Injury:	01/27/2014
Decision Date:	09/10/2014	UR Denial Date:	07/02/2014
Priority:	Standard	Application Received:	07/24/2014

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:

This is a 38-year-old female with a 1/27/14 date of injury. The mechanism of injury was repetitive office/computer work. According to a 5/28/14 progress report, the patient stated that her right arm pain is improving. She was having migraines and sinusitis and she was sleeping upright for a few months. She has completed 5/12 sessions of occupational therapy. Her pain was aggravated by typing and picking up files and relieved by steroids. Objective findings are tenderness to palpation of bilateral cervical paraspinals, bilateral suboccipital region, and bilateral upper trapezius/levator scapula; moderate tenderness to palpation elbow wrist flexors and extensors. Diagnostic impression included right lateral epicondylitis, right medial epicondylitis, and right ulnar neuritis. Treatment to date is medication management, activity modification, and occupational therapy. A UR decision dated 7/2/14 denied the requests for 12 chiropractic sessions and one interferential unit. Regarding chiropractic sessions, the request did not specify the anatomical area to be treated. Therefore, the current request for chiropractic treatment is denied at this time because of a lack of necessary medical information. Regarding interferential unit, MTUS does not support interferential treatment. Therefore, the request for an interferential unit is denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment for twelve (12) treatments: 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 & Manipulation Page(s): 57.

Decision rationale: CA MTUS states that manipulation is 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 return to work (RTW) was 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. According to the reports reviewed, the patient has received occupational therapy treatment. However, the type of treatment was not specified. In addition, the anatomical area to be treated was not specified. Guideline recommendations cannot be applied without knowledge of the specific condition being treated. Therefore, the request for chiropractic treatment for twelve (12) treatments was not medically necessary.

Interferential unit (quantity 1): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

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

Decision rationale: Chronic Pain Medical Treatment Guidelines state that a one-month trial may be appropriate when pain is ineffectively controlled due to diminished effectiveness of medications; or pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or significant pain from postoperative conditions limits the ability to perform; exercise programs/physical therapy treatment; or unresponsive to conservative measures. It is unclear what type of occupational treatment the patient has received. In addition, there is no documentation that the patient's pain has been unresponsive to conservative measures. Therefore, the request for one interferential unit was not medically necessary.