MAXIMUS Federal Services

Case Number:	CM14-0031408		
Date Assigned:	06/20/2014	Date of Injury:	10/22/2006
Decision Date:	07/21/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	03/12/2014

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 American Board of Orthopedic Surgery, 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 injured worker is a 56-year old male, injured on October 22, 2006. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated on March 5, 2014, indicated that there are were ongoing complaints of neck pain, low back pain and arm pain noted to be 5/10 on the visual analog scale. The physical examination demonstrated 5 feet 8 inches, 168 pound individual with a decreased cervical spine range of motion and evidence of a radiculopathy at C6-C7. A positive impingement sign of the right shoulder was noted with a reduced range of motion. Diagnostic imaging studies objectified evidence of muscle spasm and ordinary disease of life degenerative disc disease with desiccation. Similar degenerative changes were noted in the cervical spine. Previous treatment included multiple medications, transcutaneous electrical nerve stimulation (TENS) unit and chiropractic care, a request had been made for TENS and was not certified in the pre-authorization process on February 18, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS/EMS UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 116, 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Transcutaneous Electrotherapy Page(s): 114-116 of 127.

Decision rationale: Per Chronic Pain Medical Treatment Guidelines, there is no recommendation to use this as a primary treatment modality. While noting that there were some subjective declarations of modest improvement, there is no objectification of a decrease in the pain complaints, a decrease in the amount of analgesic medications being employed or an increase in functionality. Therefore, based on the clinical data presented for review and by the parameters noted in the Chronic Pain Medical Treatment Guidelines, this is not medically necessary.

MRI of the neck: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 49 of 127.

Decision rationale: Previous imaging studies have objectified multiple level degenerative disc disease and osteoarthritic changes. There is nothing in the progress notes indicating an increasing pathology or need for a repeat study. Therefore, based on the data presented, this request is not medically necessary.

12 visits of chiropractic treatments (2x6): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. (Effective July 18, 2009) Page(s): 58-59 of 127.

Decision rationale: Per Chronic Pain Medical Treatment Guidelines, there is no clinical indication for any additional chiropractic care at this time. The premise to establish good effect is 4-6 visits and has been accomplished. Maximum duration of time is noted to be 8 weeks. Each of these parameters has passed. Therefore, based on the clinical information presented for review, this request is not medically necessary.

Urinalysis to be performed periodically: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain chapter 4) On-going management (e.), criteria for use Page(s): 78..

Decision rationale: There is absolutely no indication of any inappropriate or illicit medication usage. There is no clinical indication presented to support the need for periodic drug screening on an open-ended scale. Therefore, with no specific narrative as to why this is necessary, this is not medically necessary.