

Case Number:	CM14-0089459		
Date Assigned:	07/23/2014	Date of Injury:	05/07/2013
Decision Date:	09/08/2014	UR Denial Date:	05/22/2014
Priority:	Standard	Application Received:	06/13/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in 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 19 year old female whose date of injury is 05/07/2013. The injured worker was cleaning a window and felt a popping sensation along with numbness and tingling that traveled from the upper back to the right shoulder and into the right hand. The injured worker was seen and diagnosed with a shoulder strain. Electromyography and nerve conduction velocity (EMG/NCV) dated 06/13/13 is a normal study. MRI of the right shoulder dated 11/06/13 is essentially normal.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy x 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back (Updated 4/14/14) Physical Therapy Treatment Official Disability Guidelines: Low Back (Updated 5/12/14) Physical Therapy Treatment Official Disability Guidelines: Shoulder (Updated 4/25/14) Physical Therapy Treatment Official Disability Guidelines: Elbow (Updated 5/15/14) Physical Therapy Treatment Official Disability Guidelines: Carpal Tunnel Syndrome (updated 2/20/14) Physical Therapy Treatment Official Disability Guidelines: Forearm, Wrist, & Hand (Updated 2/18/14) Physical Therapy Treatment Official Disability Guidelines: Low Back- Lumbar & Thoracic (Acute & Chronic) (Updated 5/12/14).

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

Decision rationale: There is no comprehensive assessment of treatment completed to date or the patient's response submitted for review. There is no current, detailed physical examination submitted for review and no specific, time limited treatment goals are provided. California Medical Treatment Utilization Schedule (MTUS) guidelines would support one to two visits every four to six months for recurrence/flare up and note that elective or maintenance care is not medically necessary. Based on the clinical information provided, the request for physical therapy twelve sessions is not recommended as medically necessary.

Multi Interferential Stimulator x 1 Month Rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy; Criteria for the use of TENS Page(s): 116, 120-121.

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

Decision rationale: Based on the clinical information provided, the request for multi interferential stimulator for a one month rental is not recommended as medically necessary. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no current, detailed physical examination submitted for review and no specific, time limited treatment goals are provided as required by California Medical Treatment Utilization Schedule (MTUS) guidelines. Therefore, the request is not in accordance with current evidence based guidelines, and medical necessity is not established.

Lumbosacral Orthosis (LSO Brace Lumbosacral Orthosis): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, Lumbar supports.

Decision rationale: Based on the clinical information provided, the request for lumbosacral orthosis is not recommended as medically necessary. There are no radiographic reports/imaging studies of the lumbar spine submitted for review. There is no documentation of spondylolisthesis, instability or compression fracture as required by the Official Disability Guidelines. There is no clear rationale provided to support the requested orthosis at this time.