MAXIMUS Federal Services

Case Number:	CM14-0095348		
Date Assigned:	07/25/2014	Date of Injury:	08/21/2013
Decision Date:	09/11/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/23/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 44-year-old male who reported an injury on 08/21/2013 due to repetitive trauma. The injured worker reportedly sustained an injury to his left shoulder and cervical spine. The injured worker was evaluated on 03/03/2014. It was noted that the injured worker had left shoulder and cervical spine pain complaints. Physical findings included tenderness to palpation of the acromioclavicular joint of the left shoulder with a positive cross arm test, and a positive impingement sign. Evaluation of the cervical spine revealed tenderness to palpation with a positive compression test with a restricted range of motion secondary to pain. The injured worker's diagnoses included left shoulder strain, cervical spine sprain/strain. The injured worker's treatment plan included physiotherapy from a chiropractor, continued medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment with Physiotherapeutic Modalities and Exercise two (2) times a week for four (4) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-Treatment in Workman's Compensation (TWC): Neck and Upper Back Procedure Summary; Official Disability Guidelines (ODG): Chiropractic Guidelines;Official Disability Guidelines (ODG): Shoulder Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit, H-Wave Therapy, Interferential Stimulation, and Galvanic therapy Page(s): 11-120.

Decision rationale: The requested chiropractic treatment with physiotherapeutic modalities and exercise 2 times a week for 4 weeks is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends continued manual therapy and manual therapy and manipulation be supported by documented functional increases and symptoms relief resulting from prior treatments. The clinical documentation submitted for review does indicate that the injured worker has already participated in chiropractic treatment. However, significant functional increases and pain relief resulting from that treatment were not provided. Therefore, additional chiropractic treatment would not be supported. Furthermore, the request does not specifically identify an applicable body part. In the absence of this information the appropriateness of the request itself cannot be determined. As such, the requested chiropractic treatment with physiotherapeutic modalities and exercise 2 times a week for 4 weeks is not medically necessary or appropriate.

Ortho-Stim4/Interferential Stimulator Unit Rental with Supplies for two (2) months: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit, H-Wave Therapy, Interferential Stimulation, and Galvanic therapy Page(s): 111-120.

Decision rationale: The requested ortho-Stim 4/interferential stimulator unit is not medically necessary or appropriate. The requested durable medical equipment is a compounded piece of equipment that contains an interferential stimulator, a TENS stimulator, an H-wave stimulator and a galvanic stimulator. California Medical Treatment Utilization Schedule does not recommend galvanic stimulation. Furthermore, California Medical Treatment Utilization Schedule recommends the use of an interferential stimulation for patients who have failed to respond to a TENS unit. The clinical documentation does not provide any evidence that the injured worker has failed to respond to other treatments such as a TENS unit. Furthermore, the request as it is submitted does not clearly identify an applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Ortho-Stim 4/interferential stimulator unit rental with supplies for 2 months is not medically necessary or appropriate.