

Case Number:	CM14-0185569		
Date Assigned:	11/13/2014	Date of Injury:	08/01/2014
Decision Date:	02/18/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	11/07/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabn

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 patient is a 66 year old female with date of injury 08/01/14. The treating physician report dated 09/10/14 indicates that the patient presents with pain affecting her right forearm/wrist/hand, right shoulder, neck, mid back, lower back, and headaches. (61) The physical examination findings reveal decreased range of motion, tenderness to palpation on the cervical and lumbar spine, upper right extremity grip was measured as 10kg and left was 20 kg, and decreased range of motion in the right wrist. Prior treatment history includes chiropractic, physical therapy, and medications. X-ray findings from 2014 reveal moderate to severe L5-S1 disc space narrowing with slight L5-S1 facet changes and MRI findings from 2010 reveal mild degenerative changes without evidence of significant central canal or neuroforaminal stenosis. The current diagnoses are: 1. Right Elbow/ Wrist/ Extensor/Flexor Tendinitis with Severe Atrophy of the Extensor Musculature for the Forearm Secondary to Radial Nerve Injury 2. Right Shoulder Periscapular Strain with Impingement/ Tendinitis 3. Cervical Sprain/Strain 4. Thoracic Sprain/Strain 5. Lumbar Sprain/Strain 6. Headaches. The utilization review report dated 11/03/14 denied the request for Chiropractic treatment two times a week for four weeks for the cervical spine, thoracic spine, lumbar spine, right shoulder, right elbow and right wrist and Inferential stimulator unit based on medical necessity and guidelines not being met.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment two times a week for four weeks for the cervical spine, thoracic spine, lumbar spine, right shoulder, right elbow and right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-59.

Decision rationale: The patient presents with pain affecting her right forearm/wrist/hand, right shoulder, neck, mid back, lower back, and headaches. The current request is for Chiropractic treatment two times a week for four weeks for the cervical spine, thoracic spine, lumbar spine, right shoulder, right elbow and right wrist. The treating physician states that the patient is improving due to the chiropractic treatment. (27) The MTUS guidelines state, "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. Forearm, Wrist, & Hand: Not recommended." The MTUS guidelines support initial chiropractic treatment of 6 visits and with functional improvement up to 18 visits. In this case, the treating physician has asked for additional visits. The amount of previous chiropractic visits the patient has completed is unknown. Without knowing the quantity of visits already received there is no way to know if the current request is within the MTUS guideline recommendation for continued care. Recommendation is for denial.

Inferential stimulator unit: Upheld

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

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

Decision rationale: The patient presents with pain affecting her right forearm/wrist/hand, right shoulder, neck, mid back, lower back, and headaches. The current request is for interferential stimulator unit. The treating physician states that the patient has been improving with chiropractic care which included the use of an inferential stimulator unit (28) The MTUS guidelines state, "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. 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 (e.g., repositioning, heat/ice, etc.)." In this case, the treating physician has not documented if the pain is ineffectively controlled with medication or if the patient has been unresponsive to other therapies. Additionally, MTUS states that if the choice to go against the recommendation of

isolated intervention then the patient selection criteria are to be followed and if the criteria are met then a one month trial may be appropriate to evaluate for functional improvement. This request is not medically necessary as the criteria have not been met and the request is for a purchase not a one month trial as recommended by MTUS. Recommendation is for denial.