

Case Number:	CM14-0196006		
Date Assigned:	12/19/2014	Date of Injury:	09/22/2014
Decision Date:	05/01/2015	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	11/24/2014

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. 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: New York
 Certification(s)/Specialty: Internal Medicine

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 sustained a work related injury on September 22, 2014, sustaining multiple body parts injuries from working as a machine operator. The Primary Treating Physician's report dated November 19, 2014, noted the injured worker with neck, shoulder, knee, ankles, and back pain. The UR Physician noted the diagnoses as cervical/trapezial/thoracic, bilateral shoulders, bilateral knees, and bilateral ankles sprains/strains, bilateral elbow olecranon bursitis, and stress/sleep loss. The injured worker had been participating in chiropractic care starting on November 3, 2014. The Physician had requested authorization for a diagnostic ultrasound of the right shoulder, a diagnostic ultrasound of the left knee, eight chiropractic treatment to the neck/thoracic spine, eight chiropractic treatment to the elbows/knees/ankles, a two channel home interferential unit, a psychiatric evaluation, and a review of medical records to prepare a narrative report. On October 31, 2014, Utilization Review evaluated the request for a diagnostic ultrasound of the right shoulder, a diagnostic ultrasound of the left knee, eight chiropractic treatment to the neck/thoracic spine, eight chiropractic treatment to the elbows/knees/ankles, a two channel home interferential unit, a psychiatric evaluation, and a review of medical records to prepare a narrative report, citing the MTUS American College of Environmental Medicine (ACOEM), the Chronic Pain Medical Treatment Guidelines, and the Official Disability Guidelines (ODG) Shoulder and Knee Chapters. The UR Physician noted the diagnostic ultrasound of the right shoulder and the psychiatric evaluation were approved. The UR Physician noted there was no documented MRI and the guideline criteria for the ultrasound of the left knee was not met, therefore the request was not medically necessary. The UR Physician

noted the chiropractic treatment to the neck/thoracic spine would be indicated, however at a modified number of six to allow for demonstration of functional improvement and/or decreased pain. The UR Physician noted the chiropractic treatment to the elbows, knees, and ankles not medically necessary as there were limited large scale long term references showing safety and efficacy of the treatment for the injured worker's clinical scenario with the guidelines not being met. The UR Physician noted the two channel interferential unit not medically reasonable or necessary, as there was no evidence that the injured worker had extenuating circumstances that would meet the guideline criteria. The UR Physician noted the review of medical records was considered part of the usual and customary examination and was therefore not medically necessary. The decisions were subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment to the neck/thoracic spine time 8: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-59.

Decision rationale: As per MTUS Chronic pain guidelines, chiropractic is not recommended anywhere except for the low back. ODG Guidelines recommend a trial of 6 Chiropractic visits over 2-3 weeks for neck pain due to cervical strain. The primary criterion for continued treatment is based on patient response. With evidence of objective functional improvement, a total of up to 18 visits over 6-8 weeks may be prescribed. Documentation reveals that the injured worker has had 6 Chiropractic visits to date with no objective functional improvement. No other evidence is provided of functional improvement. Given that this injured worker has completed a course of Chiropractic therapy, which meets the quantity recommended by the MTUS and ODG as an initial course and the lack of physician reports describing specific functional improvement, the medical necessity for further Chiropractic therapy has not been established. The request for Chiropractic treatment to the neck/thoracic spine times 8 is not medically necessary based on lack of functional improvement and by MTUS.

Diagnostic ultrasound of left knee: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC (Official Disability Guidelines-Treatment Workers Compensation) Knee Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Knee and Leg>, <Ultrasound, diagnostic>.

Decision rationale: MTUS Chronic pain and ACOEM Guidelines do not have any sections that relate to this topic. As per Official Disability Guidelines, ultrasound of knees is only recommended for assessment of certain ligamentous injuries but MRI is a superior test. Documentation fails to show previous MRI of the knee and there is no evidence of acute exacerbation of symptoms or clinical suspicion of ligamentous injuries to justify the request for an ultrasound. The request for Diagnostic ultrasound of left knee is not medically necessary.

Chiropractic treatment to the elbows, knees and ankles: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manipulation, manual therapy Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-59.

Decision rationale: As per MTUS Chronic pain guidelines, chiropractic is not recommended anywhere except for the low back. Per guidelines, Chiropractic treatment is recommended for chronic pain if caused by musculoskeletal conditions. MTUS does not recommend Chiropractic treatment for the Ankles, forearms or knees. With guidelines not being met, the request for Chiropractic treatment to the elbows, knees and ankles is not medically necessary.

2-channel home interferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

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

Decision rationale: As per MTUS Chronic pain guidelines, Interferential Current Stimulation is not recommended as isolated modality. There is very little evidence to show it is superior to standard Transcutaneous Electrical Nerve Stimulation (TENS). There is no documentation of failure of standard therapy or poor pain control on medication. Documentation does not support that the injured worker's condition meets criteria for the use of interferential unit. The request for 2-channel home interferential unit is not medically necessary by MTUS.