

Case Number:	CM14-0198409		
Date Assigned:	12/08/2014	Date of Injury:	08/01/2014
Decision Date:	02/12/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	11/25/2014

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 Internal Medicine 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 66-year-old woman with a date of injury of August 1, 2014. The mechanism of injury is documented as cumulative trauma. The current diagnoses are right elbow/wrist extensor/flexor tendinitis with severe atrophy of the extensor musculature of the forearm secondary to radial nerve entrapment/injury; right shoulder periscapular strain with impingement/tendinitis; cervical musculoligamentous sprain/strain with right upper extremity radiculitis; thoracic musculoligamentous sprain/strain; lumbar musculoligamentous sprain/strain; and headaches. Documentation indicated that the IW was under the care of neurologist who recommended physical therapy. She received 5 of her authorized 12 sessions. There is a chiropractic evaluation in the medical report dated September 24, 2014 that is handwritten and largely illegible. Subsequent noted revealed the same. Pursuant to the Doctor's First Report of Occupational Injury or Illness dated September 10, 2014, the IW presents requesting a change in her treating physician to the current office. The IW complains of right forearm, wrist and hand pain with atrophy of the extensor muscle with numbness and tingling; right shoulder and arm pain; neck pain; mid back pain; lower back pain; and headaches. On examination, range of motion (ROM) of the cervical spine is 45 degrees for flexion, 48 degrees for extension, 55 degrees for right rotation, 50 degrees for left rotation, 25 degrees for right side bending, and 50 degrees for left side bending. There is tenderness to palpation, right greater than left. There is decreased wrist ROM, muscle atrophy, and decreased sensation in the radial nerve distribution. The right shoulder exhibits crepitus and slight forward impingement. ROM is 140 degrees for elevation and abduction, and 70/80 degrees for internal/external rotation. The current request is for chiropractic treatment 2 times a week for 4 weeks to the cervical spine, thoracic spine, lumbar spine, right shoulder, right elbow, and right wrist; and an Interferential Unit (IF).

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment twice 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, Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 181, 203, 265, 298-99. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Elbow Procedure Summary (updated 5/15/14)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Neck, Low Back, Shoulder, Elbow and Wrist Sections, Chiropractic Treatment

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, chiropractic treatment twice a week for four weeks to the cervical spine, thoracic spine, lumbar spine, right shoulder, right elbow and right wrist is not medically necessary. The Official Disability Guidelines enumerate the frequency and duration for treatment. Therapeutic care, mild - up to six visits over two weeks. Severe - trial of six visits over two weeks, with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks, if acute, avoid criticism. The ACOEM notes any manipulation appears safe and effective in the first few weeks of back pain without radiculopathy. Manipulation has not been proven effective for patients with pain in the hand, wrist or forearm. Official Disability Guidelines for the elbow permit three visits contingent on objective functional improvement. In this case, the injured worker's working diagnoses are right elbow/wrist extensor/flexor tendinitis with severe atrophy of the extensor musculature of the forearm secondary to radial nerve entrapment/injury; right shoulder. Scapula strain with impingement tendinitis; cervical sprain/strain with right upper extremity radiculitis; lumbar strain/strain; and headaches. The physician's first report of occupational injury or illness dated September 10, 2014 is typed/transcribed and detailed. However, under the treatment rendered section the spaces are blank. The treating physician is requesting additional chiropractic treatment twice a week for four weeks to the cervical spine, thoracic spine, lumbar spine, right shoulder, right elbow and right wrist. The guidelines permit up to six visits over two weeks with mild symptoms and the trial of six visits over two weeks with severe symptoms, with evidence of objective functional improvement. There is no documentation in the medical record indicating objective functional improvement as a result of the initial authorized chiropractic treatment. The chiropractic notes in the medical record are hand written and largely illegible. Consequently, absent the appropriate clinical indication and documentation containing objective functional improvement from the treating chiropractor, chiropractic treatment twice a week for four weeks to the cervical spine, thoracic spine, lumbar spine, right shoulder, right elbow and right wrist is not medically necessary.

Interferential stimulator unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Section, Interferential Stimulator Unit

Decision rationale: Pursuant to the Official Disability Guidelines, interferential stimulator (ICS) unit is not medically necessary. ICS is not recommended as isolated intervention. There is no quality evidence of effectiveness except in conjunction with the recommended treatments, including return to work, exercise and medications. Randomized trials have evaluated the effectiveness of this treatment, however the trials will either negative or insufficient for recommendation due to poor study design for methodologic issues. The ODG enumerate Patient Selection Criteria that should be documented by the medical care provider for the ICS to be determined to be medically necessary. The patient selection criteria include, but are not limited to, pain is effectively controlled due to diminished effectiveness of medications; or pain is effectively control the side effects; or history of substance abuse; significant pain from the acute condition that limits the ability to perform exercise program for physical therapy; etc. If these criteria are met, and a one month trial may be appropriate to permit the physician and physical therapy provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. In this case, the injured workers working diagnoses are right elbow/wrist extensor/flexor tendinitis with severe atrophy of the extensor musculature of the forearm secondary to radial nerve entrapment/injury; right shoulder. Scapula strain with impingement tendinitis; cervical sprain/strain with right upper extremity radiculitis; lumbar strain/strain; and headaches. The physician's first report of occupational injury or illness dated September 10, 2014 is typed/transcribed and very detailed. However, under the treatment rendered section the spaces blank. There is no documentation, discussion, clinical rationale for the interferential stimulator unit. None of the Patient Selection Criteria pursuant to the Official Disability Guidelines (patient selection criteria) were documented in the medical record. Additionally, the request for an interferential stimulator unit did not state whether it was for rental or for purchase. Consequently, absent the required Patient Selection Criteria (to be documented in the medical record), ICS clinical indications and ICS clinical rationale, and whether the unit is for rental or purchase, the interferential stimulator unit is not medically necessary.