MAXIMUS Federal Services

Case Number:	CM15-0164179		
Date Assigned:	09/01/2015	Date of Injury:	02/17/2014
Decision Date:	10/05/2015	UR Denial Date:	07/27/2015
Priority:	Standard	Application Received:	08/21/2015

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 Jersey, New York
Certification(s)/Specialty: Family Practice

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 46 year old male, who sustained an industrial injury on 8-21-1994. The mechanism of injury is unknown. The injured worker was diagnosed as having cervical-thoracic-lumbar sprain-strain, bilateral shoulder impingement syndrome, bilateral wrist-hand-hip-ankle sprain-strain and right knee sprain-strain. Left shoulder magnetic resonance imaging showed acromioclavicular osteoarthritis, supraspinatus tendinosis, infraspinatus tendinosis and sub-scapularis tendinosis. Treatment to date has included 14 physical therapy visits, 28 visits of chiropractic care, 46 therapeutic activities and medication management. In a progress note dated 6-19-2015, the injured worker complains of pain in the neck, upper back and lower back with bilateral upper and lower extremity injuries. Physical examination showed tender paracervical muscles, thoracic tenderness, paralumbar tenderness, positive bilateral shoulder impingement, bilateral elbow and wrist tenderness, right knee tenderness and bilateral hip tenderness. The treating physician is requesting 4 visits of continued chiropractic evaluation and treatment to the neck, upper back, low back and right shoulder with supervised exercises for the right knee and One (1) IF unit for home use for the neck, back and right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

4 visits of continued chiropractic evaluation and treatment to the neck, upper back, low back and right shoulder with supervised exercises for the right knee: Upheld

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

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

Decision rationale: The request is considered not medically necessary. According to the chart, the patient had chiropractic care. Improvement in functional capacity was not documented. MTUS guidelines state that elective/maintenance care is not medically necessary for the low back. If a reoccurrence or flare-up occurs, there needs to be a re-evaluation of treatment success. If the patient has returned to work, then 1-2 visits, every 4-6 months. Chiropractic therapy for the knee is not recommended. However, in this limited chart, there is no documentation that he returned to work. Given these reasons, the request is not medically necessary.

One (1) IF unit for home use for the neck, back and right shoulder: 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 Page(s): 118-120.

Decision rationale: The request for ICS is not medically necessary. The patient does not meet selection criteria. He is not documented to have failed all conservative therapy. There is no documentation that his pain was not controlled by medications or he suffered side effects that would prevent him from continuing medications. A one-month trial of ICS that demonstrated increased functional improvement and less pain, with evidence of medication reduction would be necessary before prescribing home use. He was using ICS but there was no documented improvement in function. Therefore, the request is not medically necessary.