

<b>Case Number:</b>	CM15-0041475		
<b>Date Assigned:</b>	03/11/2015	<b>Date of Injury:</b>	06/04/2010
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	02/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/04/2015

### 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 year old female, who sustained an industrial injury on June 6, 2010. The injured worker was diagnosed as having diagnosis codes 847.0, 723.4, 840.9, and 726.1. Treatment to date has included recent MRIs of the cervical spine and left shoulder, medications, and a home exercise program. On January 5, 2015, the injured worker complains of a recent flare-up of the cervical spine and left shoulder. The hand-written documentation was partially legible. There is increased pain with stiffness with radiation. The pain is described as severe, constant, dull, sharp, cramping, burning, numbness, weakness, aching, and soreness. The pain was rated 9/10. The physical exam revealed paravertebral muscle guarding/spasm, more on the left than the right, to the left trapezius. There is a positive left Spurling's and decreased range of motion. The left shoulder has tenderness of the acromioclavicular (AC) and no impingement. The treatment plan includes chiropractic therapy for the cervical spine twice a week for 4 weeks and left shoulder, and an inferential stimulator.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic Treatment 2 x per week x 4 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Neck, Manipulation.

**Decision rationale:** The request is considered not medically necessary. This limited chart does not provide adequate information describing what conservative measures the patient has used in the past and what the response was. Improvement in functional capacity was not documented. ODG guidelines recommend 4-6 visits with documented functional improvement. The request is for eight sessions which would exceed the recommended amount. The patient should be able to continue with an independent home exercise program at this point. Given these reasons, the request is considered not medically necessary.

**Interferential Stimulator:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential Current Stimulation.

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

**Decision rationale:** The request for ICS is considered not medically necessary. The patient does not meet selection criteria. She is not documented to have failed all conservative therapy. There is no documentation that her pain was not controlled by medications or she suffered side effects that would prevent her 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 extended treatment. Therefore, the request is considered not medically necessary.