MAXIMUS Federal Services

Case Number:	CM15-0045407		
Date Assigned:	03/17/2015	Date of Injury:	09/10/2014
Decision Date:	04/23/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	03/10/2015

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: California, Indiana, 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 is a 41-year-old female, who sustained an industrial injury on 9/10/14. She reported neck and upper back injury. The injured worker was diagnosed as having cervical/trapezial musculoligamentous sprain/strain with bilateral upper extremity radiculitis. Treatment to date has included chiropractic treatment, activity restrictions, acupuncture and medications. (MRI) magnetic resonance imaging of cervical spine was performed on 12/19/14.Currently, the injured worker complains of neck pain radiating to bilateral shoulders, upper extremities and fingers with associated numbness and tingling. On physical exam tenderness to palpation is noted over the cervical paraspinal musculature and upper trapezius muscle with muscle spasm. The treatment plan consisted of chiropractic treatment and authorization for home interferential/moist heat units. Previous chiropractic treatments have provided some relief of her symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic manipulative therapy, 12 visits (2 times per week for 6 weeks): 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 Chiropractic Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Chiropractic manipulation.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, chiropractic sessions #12 visits (two times per week times six weeks) are not medically necessary. Manual manipulation and therapy is recommended for chronic pain is caused by musculoskeletal conditions. The intended goal or effective manual medicine is the achievement of positive symptomatic or objective measurable gains and functional improvement. Manipulation, therapeutic care-trial of 6 visits over two weeks. With evidence of objective functional improvement, total of up to 18 visits over 6 to 8 weeks. Elective/maintenance care is not medically necessary. In this case, the injured workers working diagnosis is cervical/trapezial musculoligamentous sprain/strain bilateral upper extremity radiculitis. The documentation shows the injured worker received chiropractic sessions #7 in an October 22, 2014 progress note. There were no chiropractic session notes and there was no documentation of objective functional improvements associated with those treatments. The injured worker followed up with [redacted], an orthopedist, on January 21, 2015. The orthopedist requested chiropractic manipulation two times per week from six weeks. The guidelines recommend a 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 may be indicated. However, there is no documentation of objective functional improvement associated with the first seven chiropractic treatments. Consequently, absent clinical documentation with objective functional improvement of the first seven chiropractic treatments, chiropractic sessions #12 (two times per week times six weeks) are not medically necessary.

Home interferential / moist heat unit (OS4/Thermophore): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

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 unit.

Decision rationale: Pursuant to the Official Disability Guidelines, Home Interferential unit (ICS)/moist heat unit (OS4 Thermaphore) is not medically necessary. ICS is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with the recommended treatments including return to work; exercise and medications area randomized trials have evaluated the effectiveness of this treatment. The findings from these trials were either negative or insufficient for recommendation due to poor study design and/or methodologic issues. The Patient Selection Criteria should be documented by the medical care provider for ICS to be medically necessary. These criteria include pain is an effectively controlled due to diminished effectiveness of medications; due to side effects of medications; history of substance abuse; significant pain from post operative or acute conditions that limit the ability to perform exercise programs or physical therapy; unresponsive to conservative measures.

If these criteria are met, then a one-month trial may be appropriate to permit the physician and physical therapy provider to study the effects and benefits. In this case, the injured workers working diagnosis is cervical/trapezial musculoligamentous sprain and bilateral upper extremity radiculitis. The guidelines recommend a home ICS unit if the Patient Selection Criteria are documented in the medical record and the patient receives a one-month trial. There is no documentation of one month ICS trial. Additionally, there is no documentation in the medical record the injured worker was unresponsive to conservative measures. Consequently, absent clinical documentation meeting the Patient Selection Criteria and a one month trial with an ICS unit, Home Interferential unit (ICS)/moist heat unit (OS4 Thermaphore) is not medically necessary.