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| Case Number: | CM14-0166470 | | |
| Date Assigned: | 10/13/2014 | Date of Injury: | 08/13/2014 |
| Decision Date: | 11/13/2014 | UR Denial Date: | 09/12/2014 |
| Priority: | Standard | Application Received: | 10/08/2014 |

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 patient is a 53 year old with an injury date on 8/13/14. Patient complains of cervical pain, upper mid and low lumbar pain, right > left shoulder pain, right elbow/wrist pain, and right knee pain per 9/2/14 report. Patient has not been working as she is in too much pain, but feels like pattern of symptoms are improving per 8/13/14 report. Based on the 9/2/14 progress report provided by [REDACTED] the diagnoses are: 1. cervical spine s/s2. thoracolumbar s/s3. right > left shoulder periscapular strain with tendinitis and impingement4. thoracic spine s/s5. lumbar spine s/s6. right elbow s/s7. right wrist s/sExam on 9/2/14 showed "C-spine range of motion restricted, especially flexion at 31 degrees. L-spine range of motion restricted, especially extension at 5 degrees. Bilateral shoulders range of motion restricted, with extension at 15 and flexion at 95 degrees. Right elbow range of motion is 0-120 degrees. Right wrist range of motion is restricted with radial deviation at 10 degrees. Right knee range of motion is full." [REDACTED] is requesting chiropractic therapy 3x4 visits for the cervical, thoracic, lumbar spine, bilateral shoulders, right shoulder, and right wrist, and replacement of home electrical muscle stimulation unit. The utilization review determination being challenged is dated 9/12/14. [REDACTED]. [REDACTED] is the requesting provider, and he provided treatment reports from 8/13/14 to 9/2/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy 3x4 visits for the cervical, thoracic, lumbar spine, bilateral shoulders, right shoulder, and right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 298. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Manual Therapy and Manipulation

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

Decision rationale: This patient presents with neck pain, back pain, bilateral shoulder pain, right elbow/wrist pain, right knee pain. Review of the reports do not show any evidence of chiropractic therapy being done in the past. The provider has asked for chiropractic therapy 3x4 visits for the cervical, thoracic, lumbar spine, bilateral shoulders, right shoulder, and right wrist on 9/2/14. MTUS guidelines allow up to 18 sessions of treatments following initial trial of 3-6 if functional improvements can be documented. In this case, the patient has not had prior chiropractic treatments and trial of 3-6 sessions is indicated. The requested 12 sessions of chiropractic therapy, however, exceeds MTUS guidelines for this type of condition. Recommendation is for denial.

Replacement of home electrical muscle stimulation unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 203, 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, TENS

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: This patient presents with neck pain, back pain, bilateral shoulder pain, right elbow/wrist pain, right knee pain. The provider has asked for replacement of home electrical muscle stimulation unit on 9/2/14. Regarding neuromuscular electrical stimulation, MTUS recommends as part of rehabilitative treatment program for stroke, but not indicated for chronic pain. In this case, the patient has no history of stroke, and presents with chronic pain for which neurostimulation therapy is not recommended by MTUS. Recommendation is for denial.