MAXIMUS Federal Services

Case Number:	CM15-0002272		
Date Assigned:	01/13/2015	Date of Injury:	03/27/2013
Decision Date:	03/16/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/06/2015

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, New York, Florida
Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care 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 56-year-old male who reported an injury on 03/27/2013 due to cumulative trauma while performing normal job duties. The injured worker's diagnoses included cervical sprain, derangement of the shoulder joints, carpal tunnel syndrome, and lumbar sprain/strain. The injured worker's medications included Norco, Motrin, and docusate sodium. The injured worker's treatment history included physical therapy, left knee surgery, postoperative physical therapy, acupuncture, and multiple medications. The injured worker was evaluated on 12/09/2014. It was documented that the injured worker had reduced sensation in the bilateral hands with reduced range of motion of the cervical spine. The injured worker had tenderness to palpation over the right biceps tendon with restricted range of motion of the right shoulder and a positive impingement sign. The injured worker had a positive Tinel's sign of the right and left wrist. Inspection of the lumbar spine revealed tenderness to palpation of the paraspinal musculature with restricted range of motion and a positive straight leg raising test bilaterally. The injured worker's treatment plan included chiropractic care for the neck, right shoulder, right hand, and low back and continuation of medications. A Request for Authorization was submitted on 12/09/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 3x4 weeks for neck, right shoulder, low back: 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 Manual therapy & manipulation Page(s): 58.

Decision rationale: The requested chiropractic care 3 times a week for the neck, right shoulder, and low back are not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommend an initial course of treatment of chiropractic care for neck, shoulder, and back pain, to include 6 visits. Once functional improvement has been established during that 6 visit clinical trial, additional chiropractic care can be attempted. The clinical documentation submitted for review does indicate that the injured worker has not previously received any type of chiropractic care. Therefore, an initial 6 visit clinical trial would be supported in this clinical situation. However, the request exceeds this recommendation. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. As such, the requested chiropractic care 3 times a week for 4 weeks for the neck, right shoulder, and low back are not medically necessary or appropriate.

Chiropractic 3x4 weeks for hand: 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 Manual therapy & manipulation Page(s): 58.

Decision rationale: The requested chiropractic care 3 times a week for 4 weeks for the hand is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not support the use of manual manipulation for the hands. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. As such, the requested chiropractic care 3 times a week for 4 weeks for the hand is not medically necessary or appropriate.

EMG/NCS Bilateral Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The requested EMG/NCS for the bilateral lower extremities is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends electrodiagnostic studies for injured workers who have nonfocal neurological

deficits that require clarification and have failed to respond to conservative treatment. The clinical documentation submitted for review does not provide any indication of how an electrodiagnostic study will contribute to the treatment plan. Furthermore, there is no indication that the injured worker has received any type of physical therapy or is participating in any type of home exercise program. The clinical documentation indicates that the injured worker has not had any formal physical therapy since 10/2012. As the injured worker has multiple complaints, it is unclear what body part that physical therapy was directed to. As such, the requested EMG/NCS of the bilateral lower extremities is not medically necessary or appropriate.

MRI Right Shoulder and Low Back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-9. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Magnetic resonance imaging (MRI)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The requested MRI of the shoulder and low back are not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends imaging of the shoulder when signs and symptoms are consistent with a soft tissue injury. The clinical documentation does indicate that the injured worker has physical exam findings consistent with a soft tissue injury. However, diagnostic imaging is not supported prior to a period of conservative treatment. There is no documentation that the injured worker has had any conservative treatment since 10/2012 and it is unclear what body part that conservative treatment was directed towards. Therefore, an MRI of the right shoulder would not be supported in this clinical situation. The American College of Occupational and Environmental Medicine recommends an MRI of the low back for injured workers who have neurological deficits on physical examination that have failed to respond to conservative treatment. As it is unclear what type of conservative treatment the injured worker had previously received, imaging would not be supported in this clinical situation. Additionally, other than a straight leg raising test, there is no documentation of significant neurological dysfunction. Therefore, an MRI of the low back would not be supported in this clinical situation. As such, the requested MRI of the right shoulder and low back are not medically necessary or appropriate.