

Case Number:	CM15-0013500		
Date Assigned:	02/02/2015	Date of Injury:	03/10/2014
Decision Date:	03/25/2015	UR Denial Date:	01/02/2015
Priority:	Standard	Application Received:	01/23/2015

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: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational 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 57 year old female who sustained an industrial injury reported on 3/10/2014. She has reported radiating right shoulder, wrist, hand and thumb pain. The diagnoses have included multi-level cervical spine degenerative disc disease advanced and non-industrial; right shoulder rotator cuff tears, acromioclavicular joint arthropathy and impingement syndrome; cervicobrachial syndrome; right hand and wrist pain; and right thumb pain and tingling. Treatments to date have included consultations; diagnostic laboratory and imaging studies; extensive physical therapy and home exercise program; full ergonomic work station; and modified duties; right shoulder surgery (12/12/14); and medication management. The work status classification for this injured worker was noted to be modified work duty. On 1/2/2015, Utilization Review (UR) non-certified, for medical necessity, the request, made on 12/23/2014, for chiropractic treatments, 3 x a week x 4 weeks; and an H-wave stimulation unit for the right wrist, hand and thumb. The Medical Treatment Utilization Schedule, chronic pain medical treatment guidelines and manual therapy and manipulation and H-wave stimulation, were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment; three (3) times a week for four (4) weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation; Physical Medicine Page(s): 58; 98-99.

Decision rationale: The injured worker sustained a work related injury on 3/10/2014. The medical records provided indicate the diagnosis of multi-level cervical spine degenerative disc disease - advanced and non-industrial; right shoulder rotator cuff tears, acromioclavicular joint arthropathy and impingement syndrome; cervicobrachial syndrome; right hand and wrist pain; and right thumb pain and tingling. Treatments included extensive physical therapy and home exercise program; full ergonomic work station; and modified duties; right shoulder surgery (12/12/14); and medication management. The medical records provided for review do not indicate a medical necessity for Chiropractic Treatment; three (3) times a week for four (4) weeks. The records indicate she had extensive physical therapy; the request is for chiropractic care with therapeutic exercise and myofascial release. The MTUS recognizes two types of chiropractic care: passive and active therapy. Manual therapy and manipulation is a passive procedure, and the MTUS recommends a trial of 6 visits over 2 weeks for low back conditions; but, a total of up to 18 visits over 6-8 weeks if there is evidence of objective functional improvement. The active chiropractic care follows the physical medicine guideline of allowing a fading treatment from 3 visits a week to one visit a week for a total of 10 visits. The requested treatment exceeds the recommended initial 6 visits for manual therapy and manipulation; also, it exceeds the total of 10 visits recommended for active therapy.

H-Wave Stimulation Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT) Page(s): 117.

Decision rationale: The injured worker sustained a work related injury on 3/10/2014 . The medical records provided indicate the diagnosis of multi-level cervical spine degenerative disc disease - advanced and non-industrial; right shoulder rotator cuff tears, acromioclavicular joint arthropathy and impingement syndrome; cervicobrachial syndrome; right hand and wrist pain; and right thumb pain and tingling. Treatments included extensive physical therapy and home exercise program; full ergonomic work station; and modified duties; right shoulder surgery (12/12/14); and medication management. The medical records provided for review do not indicate a medical necessity for H-Wave Stimulation Unit. The MTUS does not recommend this as an isolated treatment; rather, a one month trial is recommended as an adjunct to an evidence based functional restoration program following failure of conservative treatment and TENs unit. The record does not indicate the injured worker has been enrolled in a functional restoration program, neither does it indicate the injured worker has failed the use of TENs unit.

