

Case Number:	CM15-0067354		
Date Assigned:	04/15/2015	Date of Injury:	11/02/2014
Decision Date:	06/30/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/09/2015

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
 Certification(s)/Specialty: Emergency 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 32 year old male who sustained an industrial injury on 11/02/14. Initial complaints include right shoulder and upper back pain. Initial diagnoses include thoracic sprain/strain. Treatments to date include physical therapy and anti-inflammatories. Diagnostic studies include a MRI of the right shoulder and multiple x-rays. Current complaints include right shoulder pain. Current diagnoses include exacerbated post-traumatic right shoulder sprain. In a progress note dated 02/10/15 the treating provider reports the plan of care as chiropractic/physical medicine modalities including joint mobilization, ultrasound, electrical muscle stimulation hat modalities with exercise ad instruction. The requested treatments are chiropractic treatments, joint mobilization, ultrasound, and electrical muscle stimulation heat modalities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic sessions QTY: 12.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

Decision rationale: The requested Chiropractic sessions QTY: 12.00, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Manual Therapy and Manipulation, Pages 58-59, recommend continued chiropractic therapy with documented objective evidence of derived functional benefit. The injured worker has right shoulder pain. The treating physician has not documented the medical necessity for chiropractic treatments beyond a trial of six sessions and then re-evaluation. The criteria noted above not having been met, Chiropractic sessions QTY: 12.00 is not medically necessary.

Joint mobilization QTY: 12.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

Decision rationale: The requested Joint mobilization QTY: 12.00, is not medically necessary. CA MTUS is silent on joint mobilization. CA MTUS Chronic Pain Treatment Guidelines, Manual Therapy and Manipulation, Pages 58-59, recommend continued chiropractic therapy with documented objective evidence of derived functional benefit. The injured worker has right shoulder pain. The treating physician has not documented the medical necessity for chiropractic treatments beyond a trial of six sessions and then re-evaluation. The criteria noted above not having been met, Joint mobilization QTY: 12.00 is not medically necessary.

Ultrasound QTY: 12.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultrasound, therapeutic Page(s): 123.

Decision rationale: The requested Ultrasound QTY: 12.00, is not medically necessary. CA Medical Treatment Utilization Schedule (MTUS), Chronic Pain Medical Treatment Guidelines, July 18, 2009 P 123, Ultrasound, therapeutic is "Not recommended." with documented objective evidence of derived functional benefit. The injured worker has right shoulder pain. The treating physician has not documented the medical necessity for this treatment as an outlier to referenced guideline negative recommendations. The criteria noted above not having been met, Ultrasound QTY: 12.00 is not medically necessary.

Electrical muscle stimulation heat modalities QTY: 12.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential current stimulation Page(s): 118-120.

Decision rationale: The requested Electrical muscle stimulation heat modalities QTY: 12.00, is not medically necessary. CA Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy, Interferential current stimulation, Page 118-120, noted that this treatment is "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. There are no published randomized trials comparing TENS to Interferential current stimulation;" and the criteria for its use are: "Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.)." with documented objective evidence of derived functional benefit. The injured worker has right shoulder pain. The treating physician has not documented any of the criteria noted above, nor a current functional rehabilitation treatment program, nor derived functional improvement from electrical stimulation including under the supervision of a licensed physical therapist. The criteria noted above not having been met, Electrical muscle stimulation heat modalities QTY: 12.00 is not medically necessary.