

<b>Case Number:</b>	CM13-0032374		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	06/11/2012
<b>Decision Date:</b>	01/29/2014	<b>UR Denial Date:</b>	09/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2013

### 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 licensed in Chiropractic, has a subspecialty in Acupuncture, 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 46 year old female with a date of injury of 6/11/12. She was diagnosed with thoracic myofasciitis, and left wrist/hand tenosynovitis according to the progress report dated 9/17/13. Cervicalgia ruled out herniated nucleus pulposus, and lumbar facet syndrome ruled out herniated nucleus pulposus. According to the progress report dated 8/15/13, the patient complained of posterior neck pain with radiation to the back of the head and the left upper extremity (5/10), upper back pain (7/10), lower back pain with radiation to the bilateral buttock (5/10), left wrist pain (6/10), right wrist pain (unrated), right shoulder pain with radiation into the neck and trapezius muscles (6/10), and left hip pain (8/10), the majority of which was described as achy and dull. The patient also complained of insomnia. She stated that the pain for the posterior neck is lessened by chiropractic, ice, and rest. Provocative factors include movement, and daily activities of living. In regards to her upper back pain, it is helped by chiropractic treatments, ice, medication, and rest; movement aggravates the condition. The pain in her right shoulder is improved by lying down, medication, and resting; movement, working, and daily activities of daily living aggravate the condition. The left hip pain is reduced by lying down and resting, while movement or prolonged activities aggravates the condition. Significant objective findings include tenderness of the bilateral cervical region, increase tonus in the cervical region, the trapezius, and the scalenus, all bilaterally. Trigger points are palpated in the erector spinae bilaterally and bilateral quadratus lumborum. There was tenderness in the snuff box, navicular, scaphoid, anterior wrist, posterior wrist, medial wrist, and lateral wrist bilaterally. There was a slight improvement in the ranges of motion compared to her initial evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**acupuncture once a week for six weeks: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The Acupuncture Medical Treatment Guidelines recommend acupuncture for pain, which the patient experiences in the posterior neck, upper back, lower back, left wrist, right wrist, right shoulder, and left hip. Guidelines recommend a trial of 3-6 sessions with a frequency of 1-3 times a week over 1-2 months to produce functional improvement. A trial of acupuncture is warranted at this time; therefore, the request is certified.

**electrical muscle stimulation twice a week for four weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 167.

**Decision rationale:** According to the ACOEM guidelines, interferential therapy is not recommended for treatment of sub-acute or chronic low back pain, chronic radicular pain syndromes, or other back-related conditions. Records indicate that the patient was experiencing chronic pain in the neck, upper back, lower back, and hip. Due to the chronic nature of the pain and the guidelines recommendations, electrical muscle stimulation twice a week for four weeks is not medically necessary at this time.

**myofascial release twice a week for four weeks: 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 Page(s): 58-60.

**Decision rationale:** Myofascial release is a form of manual therapy; the guidelines recommend manual therapy for chronic pain if it is caused by musculoskeletal conditions, beginning with a trial of 6 visits over 2 weeks. With evidence of objective functional improvement, it may be extended to a total of up to 18 visits over 6-8 weeks. Records indicate that the patient had prior care with no objective functional improvement. Therefore, the provider's request is not medically necessary at this time.

**chiropractic treatment twice a week for four weeks: 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 Page(s): 58-60.

**Decision rationale:** Records indicate that the patient had chiropractic care, and had reported that it was helpful; however, the provider failed to document any objective functional improvement in the submitted records. According to Â§ 9792.20 Medical Treatment Utilization Schedule, functional improvement is defined as either a clinically significant improvement in activities of daily living, or reduction in work restriction as measured during the history and physical exam and a reduction in dependency on continued medical treatment. Therefore, the request is non-certified.

**work conditioning twice a week for four weeks:** 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 Page(s): 125.

**Decision rationale:** Guidelines state that an adequate trial of physical and occupation therapy with improvement must take place, and then be followed by a plateau; the patient must also be unlikely to benefit from continued physical or occupational therapy, or general conditioning. Records indicate that the patient had trials of physical and chiropractic therapy with no evidence of functional improvement. Therefore, the patient did not meet the criteria for admission into the work hardening program. In addition, there was no documentation of a defined return to work goal agreed by the employer and employee. Therefore, the request is non-certified.