

<b>Case Number:</b>	CM13-0061793		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	01/13/2013
<b>Decision Date:</b>	03/26/2014	<b>UR Denial Date:</b>	11/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Medicine, and is licensed to practice in Utah. 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 physician 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 48 year old male, who works as a meat cutter. The patient's date of injury is 01/13/2013. The mechanism of injury was repetitively lifting 70 lbs boxes. The patient has been diagnosed with strain/sprain of the hand, cervical segmental dysfunction, and cholecystitis. The patient's treatments include anti-inflammatory medications, splints and physical therapy. The patient complains of mild to moderate neck and back pain, and describes it as stiff and sore in character. The physical exam findings show a normal base and stride in his walk. He had normal peripheral sensation and proprioception. He has normal muscle tone and bulk strength in all major muscle groups. His reflexes were reported at 2+ bilaterally and symmetrical. His range of motion in his neck was mildly restricted by pain, as well as in his lumbar area. He was tender in the cervical region.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic treatment 3x a week for 1 month, QTY: 12.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Manual therapy & Manipulation Page(s): 58-60.

**Decision rationale:** The MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The MTUS guidelines indicate the following: Manual Therapy and Manipulation recommendations. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended: Low back: Recommended as an option. According to the request it is unclear what the goals of manual medicine are, and what body parts would be involved in the treatment. The employee has a diagnosis for wrist/hand complaints as well as cervical neck pain. These are not areas that are recommended in the MTUS guidelines for manual treatment. According to the clinical documentation provided and current MTUS guidelines; Chiropractic treatment 3x a week for 1 month, QTY: 12.00 is not indicated as a medical necessity to the employee at this time.

**Chiropractic manipulative treatment QTY: 12.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Manual therapy & Manipulation Page(s): 58-60.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The MTUS guidelines indicate the following: Manual Therapy and Manipulation recommendations. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended: Low back: Recommended as an option. According to the request it is unclear what the goals of manual medicine are, and what body parts would be involved in the treatment. The employee has diagnoses for wrist/hand complaints as well as cervical neck pain. These are not areas that are recommended in the MTUS guidelines for manual treatment. According to the clinical documentation provided and current MTUS guidelines; Chiropractic manipulative treatment, QTY: 12.00: is not indicated as a medical necessity to the employee at this time.

**Application of a modality infrared, 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 (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Low-Level Laser Therapy Page(s): 57.

**Decision rationale:** The MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The MTUS guidelines indicate that Low-Level laser Therapy (referring to use of red-beam or near infrared lasers, is not recommended). According to the request it is unclear the type of infrared that is being requested. According to the request it is unclear what the goals of the infrared are, and what body parts would be involved in the treatment. According to the clinical documentation provided and current MTUS

guidelines, application of a modality infrared, QTY: 12.00: is not indicated as a medical necessity to the employee at this time.

**Application of a modality electrical stimulation, QTY: 12.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Transcutaneous Electrotherapy (TENS) Page(s): 114-120.

**Decision rationale:** The MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The MTUS guidelines indicate that transcutaneous electrotherapy can be used in the treatment of pain in certain cases. The request is not specific to the type of electrotherapy. Micro-current electrical stimulation or MENS devices are not recommended. According to the request it is unclear what the goals of this treatment would be, and what body parts would be involved in the treatment. According to the clinical documentation provided and current MTUS guidelines application of a modality electrical stimulation, QTY: 12.00, as is, is not indicated as a medical necessity to the employee at this time.

**Myofasc release/soft tissue mobilization, 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 Section Manual therapy & Manipulation Page(s): 58-60.

**Decision rationale:** The MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. There are no specific MTUS guidelines that recommend myofascial release as a recommended treatment as part of manual medicine. According to the request it is unclear what the goals of this treatment would be, and what body parts would be involved in the treatment. According to the clinical documentation provided and current MTUS guidelines Myofascial release/soft tissue mobilization, QTY: 12.00, as is, is not indicated as a medical necessity to the employee at this time.

**Acupuncture 2 times per week for 4 weeks, QTY: 8.00: 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 Section Back Complaints Page(s): 299-301.

**Decision rationale:** The MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The guidelines indicate for back pain that acupuncture has not been found effective in the management of back pain, based on several high-quality studies, but there is anecdotal evidence of its success. While acupuncture might have a role in the treatment of the employee, according to the request it is unclear what the goals of this treatment would be, and what body parts would be involved in the treatment. According to the clinical documentation provided and current MTUS guidelines, the request for Acupuncture 2 times per week for 4 weeks, QTY: 8.00, as is, is not indicated as a medical necessity to the employee at this time.

**Application of a modality infrared, QTY: 8.00: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Low-Level Laser Therapy Page(s): 57.

**Decision rationale:** The MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The MTUS guidelines indicate that Low-Level laser Therapy (referring to use of red-beam or near infrared lasers, is not recommended). According to the request it is unclear the type of infrared that is being requested. According to the request it is unclear what the goals of the infrared are, and what body parts would be involved in the treatment. According to the clinical documentation provided and current MTUS guidelines, Application of a modality infrared, QTY: 8.00 is not indicated as a medical necessity to the employee at this time

**Application of a modality traction, QTY: 8.00: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49..

**Decision rationale:** The MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The MTUS guidelines indicate that traction as an approach to treatment is not recommended. According to the clinical documentation provided and current MTUS guidelines, application of modality traction, QTY: 8.00 is not indicated as a medical necessity to the employee at this time.

**Myofasc release/soft tissue mobilization, QTY: 8.00: 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 Section Manual Therapy & Manipulation Page(s): 58-60.

**Decision rationale:** The MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. There are no specific MTUS guidelines that recommend myofascial release as a recommended treatment as part of manual medicine. According to the request, it is unclear what the goals of this treatment would be, and what body parts would be involved in the treatment. According to the clinical documentation provided and current MTUS guidelines, myofascial release/soft tissue mobilization, QTY: 8.00, as is, is not indicated as a medical necessity to the employee at this time.