

<b>Case Number:</b>	CM14-0007912		
<b>Date Assigned:</b>	02/10/2014	<b>Date of Injury:</b>	08/17/2013
<b>Decision Date:</b>	07/16/2014	<b>UR Denial Date:</b>	12/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2014

### 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 Board Certified in Occupational Medicine 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 47-year-old female who has filed a claim for lumbago and right ankle sprain associated with an industrial injury date of August 17, 2013. Review of progress notes indicates pain on the lateral aspect of the right ankle, right posterior talofibular ligament, and right peroneal tendon; low back pain; right knee pain located on the backside or under the patella associated with burning and numbness, radiating to the foot; and intermittent right dorsal hand pain radiating to the forearm and arm with paresthesias. Findings of the right ankle include effusion over the lateral malleolus, decreased range of motion, and tenderness over the lateral malleolus and calcaneofibular ligament. Regarding the right upper extremity, findings include tenderness over the right proximal extensor forearm musculature, positive Phalen's test of the wrist, decreased grip strength, and decreased wrist range of motion. Regarding the lumbar spine, findings include positive Kemp's test and decreased range of motion. Regarding the knee, findings include mild swelling, pain upon movement, tenderness over the medial and lateral aspects, and decreased range of motion. Patient has an antalgic gait. MRI of the right ankle dated October 23, 2013 showed a longitudinal tear of the peroneus brevis tendon. Treatment to date has included NSAIDs, opioids, Ambien, Flector patches, topical analgesics, physical therapy, and knee and ankle bracing. Utilization review from December 23, 2013 denied the requests for chiropractic therapy for the lumbar spine, right knee, and right ankle as there is sparse information regarding the lumbar spine, and chiropractic therapy is not recommended for the knee and leg; and acupuncture for the lumbar spine, right knee, and right ankle as the documentation is sparse regarding the knee, ankle, and lumbar pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CHIRO FOR LUMBAR SPINE (TWO (2) TIMES A WEEK FOR FOUR (4) WEEKS):**

Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 58.

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that the goal of manual therapy is to achieve positive symptomatic or objective measurable functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. For the low back, trial of six visits is recommended, and with evidence of objective functional improvement, a total of up to 18 visits are supported. In addition, elective/maintenance care is not medically necessary. In this case, there limited information regarding the deficits or symptoms referable to the lumbar spine. Therefore, the request is not medically necessary.

**CHIRO FOR RIGHT KNEE (TWO (2) TIMES A WEEK FOR FOUR (4) WEEKS):**

Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 369-371. Decision based on Non-MTUS Citation ODG Knee and Leg Chapter.

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that the goal of manual therapy is to achieve positive symptomatic or objective measurable functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. It is not recommended for the knee. Therefore, the request is not medically necessary.

**CHIRO FOR RIGHT ANKLE (TWO (2) TIMES A WEEK FOR FOUR (4) WEEKS):**

Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 369-371. Decision based on Non-MTUS Citation ODG Knee and Leg Chapter.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines,Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that the goal of manual therapy is to achieve positive symptomatic or objective measurable functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. It is not recommended for the ankle and foot. Therefore, the request is not medically necessary.

**ACUPUNCTURE FOR LUMBAR SPINE (TWO (2) TIMES A WEEK FOR FOUR (4) WEEKS):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 6: Pain, Suffering and the Restoration of Function, page(s) 114.

**Decision rationale:** The ACOEM Practice Guidelines, they stress the importance of a time-limited treatment plan with clearly defined functional goals, with frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician is paramount. In addition, Acupuncture Medical Treatment Guidelines state that acupuncture may be used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Functional improvement should be observed within 3-6 treatments, with treatments rendered 1 to 3 times per week and an optimum duration of 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. In this case, there is also no documentation of intolerance to pain medications, or of concurrent physical therapy or exercise program. Therefore, the request is not medically necessary.

**ACUPUNCTURE FOR RIGHT KNEE (TWO (2) TIMES A WEEK FOR FOUR (4) WEEKS):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 6: Pain, Suffering and the Restoration of Function, page(s) 114.

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