

<b>Case Number:</b>	CM14-0017461		
<b>Date Assigned:</b>	06/04/2014	<b>Date of Injury:</b>	10/25/2011
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	01/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/07/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 injured worker is a 56 female injured on 10/25/11 as a result of cumulative trauma sustained while performing her normal job duties. Diagnoses include lumbosacral radiculopathy, cervical radiculopathy, shoulder impingement, and elbow and wrist tendinitis/bursitis. Documentation indicates the injured worker complained of low back pain radiating to lower extremities with pain, paresthesia, and numbness. Physical examination revealed spasm, tenderness, and guarding noted in the paravertebral musculature of the lumbar spine with loss of range of motion, and decreased sensation bilaterally in the L5 dermatome. Additionally, the clinical note dated 12/27/13 indicated the injured worker presented complaining of worsening of numbness and tingling in the hands as well as night pain and clumsiness. Examination of the right-hand revealed positive Phalen and reverse Phalen testing. There were no recent medications listed for review. The initial request for chiro (2) times a week for (4) weeks to the cervical spine, thoracic spine, lumbar spine and bilateral upper extremities and acupuncture (3) times a week for (4) weeks to the cervical spine, thoracic spine, lumbar spine, and bilateral upper extremities was denied on 01/17/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CHIRO (2) TIMES A WEEK FOR (4) WEEKS TO THE CERVICAL SPINE, THORACIC SPINE, LUMBAR SPINE AND BILATERAL UPPER EXTREMITIES:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 59.

**Decision rationale:** As noted in CA MTUS, Chiropractic treatment for carpal tunnel syndrome is not recommended. Manipulation has not been proven effective in high quality studies for patients with carpal tunnel syndrome. Further, current guidelines indicate that a trial of 1 to 2 sessions over the first week for the first two weeks should be attempted to assess the presence of functional improvement. Additionally, there is no discussion in recent documentation regarding the use of chiropractic therapy for cervical/thoracic/lumbar spine pain. As such, the request for chiro (2) times a week for (4) weeks to the cervical spine, thoracic spine, lumbar spine and bilateral upper extremities are not medically necessary.

**ACUPUNCTURE (3) TIMES A WEEK FOR (4) WEEKS TO THE CERVICAL SPINE, THORACIC SPINE, LUMBAR SPINE, AND BILATERAL UPPER EXTREMITIES:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

**Decision rationale:** As noted in the Acupuncture Medical Treatment Guidelines, the frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed 1 to 3 times per week with an optimum duration over 1 to 2 months. Guidelines indicate the expected time to produce functional improvement is 3 to 6 treatments. Acupuncture treatments may be extended if functional improvement is documented. The request for twelve treatments exceeds the recommended trial period. As such, the request for acupuncture (3) times a week for (4) weeks to the cervical spine, thoracic spine, lumbar spine, and bilateral upper extremities are not medically necessary.