

<b>Case Number:</b>	CM14-0017722		
<b>Date Assigned:</b>	04/16/2014	<b>Date of Injury:</b>	05/02/2012
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	01/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2014

### 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 Orthopedic Surgery 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 38 year old female who reported an injury to her neck and left shoulder. A clinical note dated 07/24/13 indicated the injured worker complaining of shoulder and neck pain. The injured worker described burning sensation in the neck and across the shoulders, left greater than right. The injured worker demonstrated no significant range of motion deficits in the cervical spine. A clinical note dated 12/11/13 indicated the injured worker undergoing six sessions of physical therapy addressing the neck and shoulder complaints. The injured worker received minimal relief. Clinical note dated 01/20/14 indicated the injured worker continuing with complaints of neck pain. Numbness and tingling and weakness were identified in the left upper extremity. Spasms and tenderness continued in the paravertebral musculature of the cervical spine. Sensation was decreased over the left C6 dermatome. The injured worker had been approved for six chiropractic therapy sessions. The Utilization Review dated 01/16/14 resulted in denial for eight chiropractic therapy sessions and electrodiagnostic studies. The injured worker was identified as having undergone extensive physical therapy and chiropractic manipulation. No objective information was submitted regarding response to the previous therapeutic treatments. No information was submitted regarding bilateral upper extremities neurological issues.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CHIROPRACTIC TREATMENT 8 SESSIONS TO THE CERVICAL SPINE AND LEFT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION Page(s): 58.

**Decision rationale:** The request for eight chiropractic treatments for the cervical spine and left shoulder is not medically necessary. The clinical documentation indicates the injured worker previously undergoing acupuncture chiropractic extensive conservative treatment to address the ongoing cervical and shoulder complaints. However, no objective clinical data was submitted regarding positive response. Given this, the request is not indicated as medically necessary based on Chronic Pain Medical Treatment Guidelines.

**EMG BILATERAL UPPER EXTREMITIES:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, 2ND EDITION, HAND, WRIST AND FOREARM DISORDERS, SPECIAL STUDIES AND DIAGNOSTIC AND TREATMENT CONSIDERATIONS

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**Decision rationale:** There is an indication the injured worker is experiencing left upper extremity sensation deficits. However, no information was submitted regarding confirmation of radiculopathy component in bilateral upper extremities. Given this, the request for electrodiagnostic studies of bilateral upper extremities is not medically necessary based on American College of Occupational and Environmental Medicine (ACOEM) guidelines.

**NCV BILATERAL UPPER EXTREMITIES:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, 2ND EDITION, HAND, WRIST AND FOREARM DISORDERS, SPECIAL STUDIES AND DIAGNOSTIC AND TREATMENT CONSIDERATIONS

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**Decision rationale:** There is an indication the injured worker is experiencing left upper extremity sensation deficits. However, no information was submitted regarding confirmation of radiculopathy component in bilateral upper extremities. Given this, the request for electrodiagnostic studies (NCV) of bilateral upper extremities is not medically necessary according to American College of Occupational and Environmental Medicine (ACOEM) guidelines.

