

<b>Case Number:</b>	CM14-0125570		
<b>Date Assigned:</b>	08/11/2014	<b>Date of Injury:</b>	04/21/2014
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	07/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/07/2014

### 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 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 44-year-old female who has submitted a claim for idiopathic peripheral neuropathy associated with an industrial injury date of April 21, 2014. Medical records from 2014 were reviewed, which showed that the patient complained of on-and-off left shoulder and left hand pain radiating to the upper back with numbness and tingling sensation rated as 4 out of 10. She also complained of constant low back pain radiating to the entire back and was associated with numbness, tingling and burning sensation to the legs. Physical examination of the thoracic spine revealed tenderness with spasm of the paraspinals bilaterally and left quadratus lumborum muscle, tenderness with spasms of the left sacroiliac, decreased thoracolumbar spine range of motion, positive straight leg raise and sitting root tests, and decreased strength at 2+/5. Physical examination of the hip revealed decreased muscle strength at 2+/5. Physical examination of the left shoulder revealed tenderness with spasm of the left trapezius, tenderness of the left acromioclavicular and glenohumeral joints, decreased range of motion, positive impingement test, apprehension sign and empty can test and decreased muscle strength. Physical examination of the left hand revealed tenderness of the left carpal bones, positive Phalen's test and decreased muscle strength. Treatment to date has included medications and 6 chiropractic sessions. Utilization review from July 17, 2014 denied the request for 12 Acupuncture sessions for the left upper extremity and thoracic spine, for Range of motion and muscle strength testing for the left upper extremity and thoracic spine, 12 Chiropractic treatment with Chiropractic supervised physiotherapy for the left upper extremity and Range of motion and muscle strength testing for the left upper extremity and thoracic spine. The request for acupuncture and chiropractic treatment was modified to 6 and 9 sessions respectively because the requested amount exceeded guideline recommendations. The request for range of motion and muscle strength testing was denied because its medical necessity was not established.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Range of motion and muscle strength testing for the left upper extremity and thoracic spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Flexibility.

**Decision rationale:** The CA MTUS does not address this topic specifically. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Low Back, Flexibility was used instead. ODG states that computerized measures of range of motion are not recommended as the results are of unclear therapeutic value. In this case, there is no discussion concerning the need for variance from the guidelines as computerized testing is not recommended. It is unclear why the conventional methods for strength and range of motion testing cannot suffice. Furthermore, the present request does not specify the joint to be tested. Therefore, the request for range of motion (ROM) testing is not medically necessary.

**12 Acupuncture sessions for the left upper extremity and thoracic spine:** Upheld

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

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

**Decision rationale:** According to the Acupuncture Medical Treatment Guidelines referenced by CA MTUS, acupuncture may be used as an option when pain medication is reduced or not tolerated or as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The guidelines allow the use of acupuncture for a frequency and duration of treatment as follows: time to produce functional improvement 3-6 treatments, frequency of 1-3 times per week, and duration of 1-2 months. Additionally, acupuncture treatments may be extended if functional improvement is documented. In this case, patient may possibly benefit from acupuncture. However, the requested number of sessions exceeds the recommended initial number of sessions which is up to 6 treatments. Therefore, the request for 12 Acupuncture sessions for the left upper extremity and thoracic spine is not medically necessary.

**12 Chiropractic treatment with Chiropractic supervised physiotherapy for the left upper extremity:** 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 & Manipulation Page(s): 59-60.

**Decision rationale:** According to CA MTUS Chronic Pain Treatment Guidelines, manual therapy such as chiropractic care is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The recommended initial therapeutic care for low back is a trial of 6 visits over 2 weeks, with evidence of objective functional improvement. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Chiropractic care is not recommended for other body parts other than low back. In this case, the patient has completed 6 visits of chiropractic treatment. There was no documentation concerning the functional outcome from previous sessions to support continuation of chiropractic treatment. Furthermore, the requested chiropractic therapy is for the left upper extremity and not for the lower back. There is no clear indication for chiropractic treatment at this time. Therefore, the request 12 Chiropractic treatment with Chiropractic supervised physiotherapy for the left upper extremity is not medically necessary.

**12 Chiropractic treatment with Chiropractic supervised physiotherapy for the thoracic spine:** 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 & Manipulation Page(s): 59-60.

**Decision rationale:** According to CA MTUS Chronic Pain Treatment Guidelines, manual therapy such as chiropractic care is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The recommended initial therapeutic care for low back is a trial of 6 visits over 2 weeks, with evidence of objective functional improvement. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Chiropractic care is not recommended for other body parts other than low back. In this case, the patient has completed 6 visits of chiropractic treatment. There was no documentation concerning the functional outcome from previous sessions to support continuation of chiropractic treatment. Furthermore, the requested chiropractic therapy is for the thoracic spine and not for the lower back. There is no clear indication for chiropractic treatment at this time. Therefore, the request 12 Chiropractic treatment with Chiropractic supervised physiotherapy for the thoracic spine is not medically necessary.

