

<b>Case Number:</b>	CM14-0169838		
<b>Date Assigned:</b>	10/20/2014	<b>Date of Injury:</b>	05/07/2013
<b>Decision Date:</b>	11/20/2014	<b>UR Denial Date:</b>	10/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2014

### 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 injured worker is a 22-year-old male who sustained an injury on May 7, 2013. He is diagnosed with (a) cervicothoracic sprain/strain, (b) cephalgia, (c) thoracolumbar sprain/strain, (d) bilateral shoulder sprain, and (e) right ankle sprain. He was seen for an evaluation on August 28, 2014. He had complaints of low back pain, neck pain, headaches, bilateral shoulder pain, right ankle pain, bilateral upper and lower extremity numbness and tingling sensations, and pain in the testicular region. An examination revealed decreased range of motion, myospasm, and palpable pain in the lumbosacral, cervicothoracic, bilateral shoulders, and right ankle.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic treatment two times a week for six weeks:** 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 Chapter, Manipulation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Manipulation

**Decision rationale:** Initially, guidelines require a trial of six visits over two weeks for therapeutic care. Additional sessions of up to 18 visits over six to eight weeks may be necessary if there is evidence of objective functional improvement. The requested number of sessions was beyond the recommendation of guidelines. Therefore based on a review of the documents and per the ODG the requested Chiropractic treatment two times a week for six weeks is not medically necessary.

**NCV/EMG of the bilateral upper and lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Electromyography (EMG) Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Nerve conduction studies (NCS) Official Disability Guidelines (ODG) Low Back Chapter, EMGs (electromyography) Official Disability Guidelines (ODG) Low Back Chapter, Nerve conduction studies (NCS)

**Decision rationale:** While there were reports of numbness and tingling sensations to the bilateral upper and lower extremities, clinical findings do not suggest any significant neurologic change or compromise to warrant the need for electromyography and nerve conduction studies. Necessity of the request was not established and is therefore the request is not medically necessary.

**Back brace:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC

**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 Chapter, Lumbar supports

**Decision rationale:** Guidelines provide support for the use of back brace for treatment of nonspecific back pain. Based on the reviewed medical records, clinical scenario of the injured worker satisfied one of the indications for the use of back brace. The request for Back Brace is therefore certified. The decision for the request of back brace is reversed. Review of medical records revealed that the injured worker is in need of a back brace. One of the indications for the use of back brace as stipulated by the guidelines has been met. Therefore the request is medically necessary.

**Testicle evaluation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Introduction Page(s): 1.

**Decision rationale:** There have been no significant clinical findings in the reviewed medical records that warrant the need for testicles evaluation. Guidelines stated that a specialist evaluation is necessary only when complaints persist despite provision of appropriate management. The requested Testicle evaluation is therefore not medically necessary.