

<b>Case Number:</b>	CM14-0176440		
<b>Date Assigned:</b>	10/29/2014	<b>Date of Injury:</b>	07/19/2013
<b>Decision Date:</b>	12/12/2014	<b>UR Denial Date:</b>	10/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/24/2014

### 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 Emergency Medicine and is licensed to practice in Wisconsin. 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 62-year-old male who reported an injury on 07/19/2013 due to an unknown mechanism. Physical examination dated 07/22/2014 revealed that the injured worker was getting therapy on a weekly basis. The injured worker's wife stated that he was now riding a bike, starting to row, and was able to walk about 1 mile. It was also reported that the injured worker still had fatigue issues but volunteered a couple of hours a week. It was reported that the therapist would go with the injured worker to the volunteer work, to the gym, and on all the walks. Diagnoses were traumatic brain injury, neck pain, status post C1 through C4 fusion on 08/07/2013, status post fracture of thoracic spine, lumbar pain, right hip pain, right clavicle fracture, left upper extremity pain, status post humerus fracture, right knee pain, tracheotomy, hypertension industrially accepted, right hand pain. An addendum report dated 07/22/2014 revealed the injured worker had reduced range of motion in the shoulder less than 90 degrees for flexion. Abduction in the right shoulder reached about 90 degrees. Medications were Motrin and Tylenol, lisinopril, and flecainide. It was reported that the injured worker was making significant progress. The injured worker was exercising, and getting a lot of help, and moving in the right direction. It was also reported that the injured worker had seen an orthopedist for his shoulder problem and they are not going to operate. The rationale and Request for Authorization were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic x8 Cervical, thoracic, lumbar: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 58, Chronic Pain Treatment Guidelines Manipulation.

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

**Decision rationale:** The decision for chiropractic x8 cervical, thoracic, lumbar is not medically necessary. The California MTUS Guidelines state that chiropractic care for chronic pain if caused by musculoskeletal conditions is recommended. 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 guidelines recommend a trial of 6 visits over 2 weeks and with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks. There was a lack of documentation indicating the injured worker had significant objective functional improvement with the prior therapy. Furthermore, the guidelines recommend a trial of 6 visits over 2 weeks with evidence of objective functional improvement. The request indicates 8 visits of manual therapy. This exceeds the recommended 6 visits. Therefore, this request is not medically necessary.

**Full size [REDACTED] bed:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The decision for full size [REDACTED] bed is not medically necessary. The Official Disability Guidelines state for durable medical equipment (DME) the criteria are its ability to withstand repeated use, ability to normally be rented and used by successive patients, whether the equipment would primarily and customarily be used to serve a medical purpose (and generally is not useful to a person in the absence of illness or injury), and whether it is appropriate for use in a patient's home. The request does not meet the term "durable medical equipment" as defined by the medical guidelines. There were no other significant factors provided to justify the use of outside current guidelines. Therefore, this request is not medically necessary.