

<b>Case Number:</b>	CM14-0032371		
<b>Date Assigned:</b>	04/09/2014	<b>Date of Injury:</b>	07/27/2006
<b>Decision Date:</b>	05/28/2014	<b>UR Denial Date:</b>	01/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2014

### 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 and is licensed to practice in Illinois. 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 55-year-old male who reported an injury on 07/27/2006. The mechanism of injury was not provided. Current diagnoses include disc protrusion, cervical disc displacement, shoulder tenosynovitis, myofasciitis, and sacral ileitis. The injured worker was evaluated on 10/17/2013. The injured worker reported persistent lower back pain, neck pain, shoulder pain, and mid-back pain. Physical examination revealed limited cervical range of motion, limited lumbar range of motion, tenderness to palpation of the cervical and lumbar spine, hypertonicity in the cervical region bilaterally, positive Kemp's testing, positive straight leg raising, and 5/5 motor strength in bilateral upper extremities. Treatment recommendations included 6 chiropractic therapy sessions to include myofascial treatment and manual therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **CHIROPRACTIC MANIPULATION THERAPY 1 X 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy And Manipulation Section Page(s): 58.

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

**Decision rationale:** The California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain is caused by a musculoskeletal condition. Treatment for the low back is recommended as an option with a therapeutic trial of 6 visits over 2 weeks. The injured worker has participated in osteopathic manual manipulation. However, there is no evidence of objective functional improvement. There is also no body part listed in the current request. Therefore, the request cannot be determined as medically appropriate. As such, the request is non-certified.

#### **ELECTRONIC MUSCLE STIMULATION 1 X 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy And Manipulation Section, Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

**Decision rationale:** The California MTUS Guidelines state neuromuscular electrical stimulation is not recommended. Neuromuscular electrical stimulation is used primarily as part of a rehabilitation program following stroke, and there is no evidence to support its use in chronic pain. Therefore, the current request cannot be determined as medically appropriate. As such, the request is not medically necessary.

#### **DIATHERMY 1 X 6: 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 And Manipulation Section Page(s): 58.

**Decision rationale:** The California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain is caused by a musculoskeletal condition. Treatment for the low back is recommended as an option with a therapeutic trial of 6 visits over 2 weeks. The injured worker has participated in osteopathic manual manipulation. However, there is no evidence of objective functional improvement. There is also no body part listed in the current request. Therefore, the request cannot be determined as medically appropriate. As such, the request is not medically necessary.

#### **HYDROCULATION 1 X 6: 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 And Manipulation Section Page(s): 58.

**Decision rationale:** The California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain is caused by a musculoskeletal condition. Treatment for the low back is recommended as an option with a therapeutic trial of 6 visits over 2 weeks. The injured worker has participated in osteopathic manual manipulation. However, there is no evidence of objective functional improvement. There is also no body part listed in the current request. Therefore, the request cannot be determined as medically appropriate. As such, the request is not medically necessary.