

<b>Case Number:</b>	CM14-0059240		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	01/02/2014
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	04/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2014

### 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 41 year-old female with date of injury 01/02/2014. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 02/10/2014, lists subjective complaints as pain in the cervical spine and upper extremities, bilaterally. Objective findings included an examination of the cervical spine revealed restricted range of motion in all planes with spasm. A neurological examination was formal for sensation and light touch. There was no focal neurological deficit, C4-T1, to motor and sensory evaluation. Examination of the thoracic spine revealed decreased range of motion in all planes and spasm. The patient's diagnoses include bilateral wrist/thumb tendinitis, cervical spine strain/myofascial pain syndrome, thoracic spine strain/myofascial pain syndrome, lumbar spine strain/myofascial pain syndrome, bilateral hand numbness and insomnia. There was no mention of nerve damage, nerve injury, or nerve loss in the PR-2. The patient had an x-ray of the cervical spine on 02/10/2014 that was positive for postural changes, with no other abnormalities noted. The patient has completed 12 sessions of physical therapy and 2 sessions of occupational therapy to date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltage Actuated Sensory Nerve Conduction Threshold to Cervical and Lumbar Spine:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation AETNA Clinical Policy Bulletin Policy:

Voltage Actuated Sensory Nerve Conduction Threshold and on the Non-MTUS the Center for Medicare and Medicaid Services: Voltage Actuated Sensory Nerve Conduction Threshold.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 3. Decision based on Non-MTUS Citation AETNA Clinical Policy Bulletin, 0357.

**Decision rationale:** Voltage Actuated Sensory Nerve Conduction is considered experimental. For all conditions or injuries not addressed in the MTUS, the authorized treatment and diagnostic services in the initial management and subsequent treatment for presenting complaints shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are nationally recognized by the medical community pursuant to section 9792.25(b). There are no peer-reviewed guidelines for treatment with Voltage Actuated Sensory Nerve Conduction, and early study results are conflicting. Therefore the request is not medically necessary.

**Chiro (x12):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 107; 173. Decision based on Non-MTUS Citation Official Disability Guidelines ([http://www.odgtwc.com/odgtwc/low\\_back.htm#TreatmentPlanning; #Manipulation](http://www.odgtwc.com/odgtwc/low_back.htm#TreatmentPlanning;#Manipulation)).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 58-60.

**Decision rationale:** The request is for 12 visits of chiropractic. The Chronic Pain Medical Treatment Guidelines allow for initial 4-6 visits after which time there should be documented functional improvement prior to authorizing more visits. The request for 12 chiropractic visits is more than what is medically necessary to establish whether the treatment is effective. Therefore the request is not medically necessary.