

<b>Case Number:</b>	CM14-0079605		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	07/31/1996
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	05/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/30/2014

### 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 Preventive 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:

According to the records made available for review, this is a 63-year-old male with a 7/31/96 date of injury. At the time (5/18/14) of request for authorization for Chiropractic treatment times six, Concurrent deep transverse massage treatments times six, and Therapy of short wave diathermy for right piriformis with high volt galvanic same region, there is documentation of subjective (marked increased in right gluteal pain, increased back pain, mostly right low back with concurrent right lower extremity pain into the right/lateral posterior thigh, leg and into the lateral foot's lateral two toes on the right foot, tried to improve pain with home directed care but it is not improving or in fact increasing the intensity and effect of his activities of daily living) and objective (hypertonic and hyper-esthetic from his low right thoracic into the right lumbar paraspinal musculature primarily on the right side, deep tendon reflexes unremarkable bilaterally, dermatomes tested with Wartenberg pinwheel and remarkable for lateral two toes and lateral foot (right), decreased sensation to vibration in lateral two right toes, lumbar flexion to approximately six inches to floor, full range of motion in extension with mild increased low back pain, and pain with lateral bending) findings, current diagnoses (lumbago and disorders of sacrum), and treatment to date (home exercise program, chiropractic treatment, deep transverse massage, and short wave diathermy and high volt galvanic current). Medical report identifies a plan for six follow-up treatments with concurrent deep transverse massage focused into the right low back and deep gluteal muscles, therapy including short wave diathermy for 20 minutes before the deep transverse massage, and every other visit, adding High Volt Galvanic current, before the massage. The number of previous chiropractic treatments cannot be determined. There is no documentation of objective improvement with previous treatment and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a

reduction in the use of medications or medical services as a result of chiropractic therapy provided to date.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Chiropractic treatment times six (6): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Manual Therapy & manipulation Page(s): 58.

**Decision rationale:** MTUS reference to ACOEM identifies documentation of objective improvement with previous treatment, functional deficits, functional goals, and a statement identifying why an independent home exercise program would be insufficient to address any remaining functional deficits, as criteria necessary to support the medical necessity of additional chiropractic treatment. In addition, MTUS Chronic Pain Medical Treatment Guidelines supports a total of up to 18 visits over 6-8 weeks. Within the medical information available for review, there is documentation of diagnoses of lumbago and disorders of sacrum. In addition, there is documentation of previous chiropractic treatments, functional deficits, functional goals, and a statement that patient tried to improve pain with home directed care but it is not improving or in fact increasing the intensity and effect of his activities of daily living. However, there is no documentation of the number of previous chiropractic treatments. In addition, there is no documentation of objective improvement with previous treatment and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of chiropractic therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for Chiropractic treatment times six is not medically necessary.

#### **Concurrent deep transverse massage treatments times six (6): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Manual Therapy & manipulation Page(s): 58.

**Decision rationale:** MTUS reference to ACOEM identifies documentation of objective improvement with previous treatment, functional deficits, functional goals, and a statement identifying why an independent home exercise program would be insufficient to address any

remaining functional deficits, as criteria necessary to support the medical necessity of additional chiropractic treatment. In addition, MTUS Chronic Pain Medical Treatment Guidelines supports a total of up to 18 visits over 6-8 weeks. Within the medical information available for review, there is documentation of diagnoses of lumbago and disorders of sacrum. In addition, there is documentation of previous chiropractic treatments, functional deficits, functional goals, and a statement that patient tried to improve pain with home directed care but it is not improving or in fact increasing the intensity and effect of his activities of daily living. However, there is no documentation of the number of previous chiropractic treatments. In addition, there is no documentation of objective improvement with previous treatment and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of chiropractic therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for Concurrent deep transverse massage treatments times six is not medically necessary.

**Therapy of short wave diathermy for right piriformis with high volt galvanic same region:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Manual Therapy & manipulation Page(s): 58.

**Decision rationale:** MTUS reference to ACOEM identifies documentation of objective improvement with previous treatment, functional deficits, functional goals, and a statement identifying why an independent home exercise program would be insufficient to address any remaining functional deficits, as criteria necessary to support the medical necessity of additional chiropractic treatment. In addition, MTUS Chronic Pain Medical Treatment Guidelines supports a total of up to 18 visits over 6-8 weeks. Within the medical information available for review, there is documentation of diagnoses of lumbago and disorders of sacrum. In addition, there is documentation of previous chiropractic treatments, functional deficits, functional goals, and a statement that patient tried to improve pain with home directed care but it is not improving or in fact increasing the intensity and effect of his activities of daily living. However, there is no documentation of the number of previous chiropractic treatments. In addition, there is no documentation of objective improvement with previous treatment and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of chiropractic therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for Therapy of short wave diathermy for right piriformis with high volt galvanic same region is not medically necessary.