

<b>Case Number:</b>	CM15-0020820		
<b>Date Assigned:</b>	02/10/2015	<b>Date of Injury:</b>	07/29/2014
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	01/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/04/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

### 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 37 year old female, who sustained a work related injury on 7/29/14. She slipped on floor and fell backwards landing on her buttocks and then onto left side of body. The diagnoses have included cervical sprain/strain with left upper extremity radiculitis, left shoulder strain, left ankle sprain and right foot pain secondary to altered gait. Treatments to date have included physical therapy to left ankle with no benefit, modified work duty and medication. In the PR-2 dated 1/2/15, the injured worker complains of neck pain that radiates to left arm, left shoulder pain, left ankle pain and right foot pain. She has tenderness to palpation with spasm in cervical musculature. She has decreased range of motion in neck. She has tenderness to palpation of left shoulder musculature. The impingement and Cross Arm tests elicit posterior pain. Range of motion in shoulder is decreased. She has tenderness to palpation of left ankle joint. Range of motion is decreased in ankle joint. On 1/23/15, Utilization Review non-certified requests for chiropractic treatment 8 visits and home interferential unit. The California MTUS, Chronic Pain Treatment Guidelines, were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic Treatment 8 visits:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** Chiropractic Treatment 8 visits is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS recommends chiropractic treatment for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. 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. For the low back therapeutic care is a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Chiropractic is not recommended for the ankle & foot, forearm, wrist or hand, knee or carpal tunnel syndrome. The MTUS states that the time to produce effect is 4 to 6 treatments at a frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. The request exceeds the recommended number of trial chiropractic sessions and also the request does not specify what body part the chiropractic treatment is for therefore this request is not medically necessary.

**Home Interferential unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Intereferential Current Stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS)- Page(s): 118-120.

**Decision rationale:** Home Interferential Unit is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that the interferential unit is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Additionally, the MTUS guidelines states that an interferential unit requires a one-month trial to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. The documentation does not indicate that the patient has had this trial with outcomes of decreased medication, increased function and decreased pain. The documentation does not support the medical necessity of the home Interferential Unit.