

<b>Case Number:</b>	CM15-0016971		
<b>Date Assigned:</b>	02/03/2015	<b>Date of Injury:</b>	06/01/2011
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	01/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/27/2015

### 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: California  
 Certification(s)/Specialty: Emergency 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 50 year old female who sustained an industrial injury on 6/1/11 involving the lumbar spine and right wrist. She is currently experiencing right sided neck pain radiating to the right upper extremities and bilateral hand numbness. Laboratory evaluations to determine the level of prescription medications were done several times the latest done on 1/6/15 but no specific medications were indicated. Diagnoses include cervical radiculopathy; lumbar spine strain; lumbar herniated nucleus propulsus and bilateral wrist strain. Treatments included medications, physical and manipulative therapy, acupuncture and injections. There was no documentation of number of visits for above therapies or the effect of the treatments on the injured workers symptoms. Diagnostics were electromyogram bilateral upper extremities (12/23/14) suggesting cervical radiculopathy, acute and chronic in nature involving C5-6 nerve roots, greater on the right; nerve conduction studies suggest moderate carpal tunnel syndrome and bilateral ulnar nerve dysfunction across the elbows. MRI of the cervical spine and right shoulder were ordered 11/12/14. MRI of the left wrist (10/14/14) indicated ganglion cyst; MRI of the right (10/9/14) indicated subchondral cyst; MRI of the lumbar spine (9/11/14) indicated early disc desiccation at L1-2. Progress notes from 12/8/14 and 1/6/15 were illegible. On 1/7/15 Utilization review non-certified the request for chirotherapy-physiotherapy of the lumbar spine and bilateral wrists citing ODG: Physical Therapy, Chiropractic Therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chirotherapy - physiotherapy of the lumbar and bilateral wrists: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, Last updated: May 2009, Effective 07/18/2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Guidelines, Chiropractic Therapy; Physical Therapy, Online Version 2014

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation, Pages 58-60 Page(s): 58-60. Decision based on Non-MTUS Citation ODG Physical Therapy Guidelines, Low Back Complaints, Physical Therapy

**Decision rationale:** The requested Chirotherapy - physiotherapy of the lumbar and bilateral wrists , is not medically necessary.CA MTUS, ACOEM 2nd Edition, 2004, Chapter 12, Low Back Complaints, Page 300 and ODG Treatment in Workers Compensation, ODG Physical Therapy Guidelines, Low Back Complaints, Physical Therapy, recommend continued physical therapy with documented derived functional benefit.CA MTUS Chronic Pain Treatment Guidelines, Manual Therapy and Manipulation, Pages 58-60, recommend continued chiropractic therapy with documented derived functional improvement. The injured worker has right sided neck pain radiating to the right upper extremities and bilateral hand numbness. The treating physician has not documented objective evidence of derived functional improvement from completed chiropractic physiotherapy sessions.The criteria noted above not having been met, Chirotherapy - physiotherapy of the lumbar and bilateral wrists is not medically necessary.