

<b>Case Number:</b>	CM15-0113975		
<b>Date Assigned:</b>	06/19/2015	<b>Date of Injury:</b>	12/07/2002
<b>Decision Date:</b>	07/20/2015	<b>UR Denial Date:</b>	05/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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: Arizona, California

Certification(s)/Specialty: Family Practice

### 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 52-year-old female who sustained an industrial injury on 12/07/2002. Mechanism of injury was not documented. Diagnoses include chronic trochanteric bursitis, cervical degenerative disc disease, and degenerative disc disease L2-L3. Treatment to date has included diagnostic studies, medications, acupuncture, chiropractic sessions, physical therapy, and a home exercise program with [REDACTED] Home Therapy kit. A physician progress note dated 04/09/2015 documents the injured worker complains of a slight aggravation in her neck symptoms from 3 out of 10 up to 4 out of 10, and the neck discomfort travels to both sides of the scalp. She also complains of headaches. Her left hip pain is rated as 3 out of 10 on the pain scale. She does continue to work. Cervical range of motion is limited. Right shoulder depression test is positive for increased radiculitis from right side mid neck into the right upper extremity shoulder area. Her right upper trapezius displays moderate myospasm as compared to the left. Her left hip flexion in the supine position shows a slight restriction at end range. Left lateral abduction creates slight irritation in the medial portion of the left hip joint at the vastus medialis origin area. Treatment requested is for Acupuncture 1-3x/ 4 weeks, and Chiropractic 3x4.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture 1-3x/ 4 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (<http://www.odg-twc.com/odgtwc/pain.htm>)[http://www.coworkforce.com/dwc/Medical\\_Treatment.asp](http://www.coworkforce.com/dwc/Medical_Treatment.asp).

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** Acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Time to produce functional improvement: 3 to 6 treatments. In this case, the claimant had been undergoing acupuncture for several months. Progress notes regarding intervention were not provided. The additional 12 sessions requested exceed the amount recommended to obtain functional improvement and is not medically necessary.

**Chiropractic 3x4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

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

**Decision rationale:** According to the MTUS guidelines, Chiropractic therapy is considered manual therapy. It is recommended for chronic musculoskeletal pain. For Low back pain, therapeutic care is for 6 visits over 2 weeks with functional improvement up to a maximum of 18 visits over 8 weeks. In this case the claimant had undergone numerous chiropractor weekly sessions over the past 5 months. Progress notes from manipulation were not provided. The additional 12 sessions requested exceed the amount recommended by the guidelines and is not medically necessary.