

<b>Case Number:</b>	CM15-0078364		
<b>Date Assigned:</b>	04/29/2015	<b>Date of Injury:</b>	01/08/2009
<b>Decision Date:</b>	05/28/2015	<b>UR Denial Date:</b>	04/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/23/2015

### 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: North Carolina  
 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 43 year old male, who sustained an industrial injury on 01/08/2009. He has reported subsequent low back, neck, right shoulder, left knee and left wrist pain and was diagnosed with chronic postsurgical low back, right shoulder and left knee pain, L5-S1 bilateral radiculopathy, cervical radiculitis and left wrist tendonitis. Treatment to date has included oral pain medication, TENS unit, acupuncture and a home exercise program. In a progress note dated 04/01/2015, the injured worker complained of bilateral shoulder, low back, left knee, neck pain and headaches. Objective findings were notable for tenderness of the bilateral shoulders, lumbar paraspinal muscles and sacroiliac joints, left knee and left elbow and decreased range of motion of the left shoulder and left knee. A request for authorization of chiropractic treatment for the lumbar and cervical spine (3 times a week for 4 weeks), local injections to the left elbow for the triceps tendon and common extensor tendon and orthopedic consultation for the left shoulder was submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic treatment for the lumbar and cervical spine, three times a week for four weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Manipulation Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines manual manipulation Page(s): 58-59.

**Decision rationale:** The California chronic pain medical guidelines section on manual manipulation states: Recommended 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. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines. A. Time to produce effect: 4 to 6 treatments. Manual manipulation is recommended form of treatment for chronic pain. However the requested amount of therapy sessions is in excess of the recommendations per the California MTUS. The California MTUS states there should be not more than 6 visits over 2 weeks and documented evidence of functional improvement before continuation of therapy. The request is for greater than 6 sessions. This does not meet criteria guidelines and thus is not certified. Therefore, the requested treatment is not medically necessary.

**Local injections to the left elbow for the triceps tendon and common extensor tendon:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 235-236. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

**Decision rationale:** There is good evidence that glucocorticoid injections reduce lateral epicondylar pain. However, there is also good evidence that the recurrence rates are high. On the other hand, pain at the time of recurrence is generally not as severe. Thus, despite the problems with recurrence, there is support for utilizing corticosteroid injections in select cases to help decrease overall pain problems during the disorders natural recovery or improvement phase. Quality studies are available on glucocorticoid injections and there is evidence of short-term benefits, but not long-term benefits. This option is invasive, but is low cost and has few side effects. Thus, if a non-invasive treatment strategy fails to improve the condition over a period of at least 3-4 weeks, glucocorticoid injections are recommended [Evidence (B), Moderately

Recommended]. The patient does not have epicondylar pain and the ODG does not recommend routine elbow injections for other diagnoses. Therefore the request is not certified. Therefore, the requested treatment is not medically necessary.

**Orthopedic Consultation for the left shoulder:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 127. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 3 Initial Approaches to Treatment.

**Decision rationale:** Per the ACOEM :The health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for 1. Consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The patient has ongoing complaints of shoulder pain that have failed treatment by the primary treating physician. Therefore criteria for a consult have been met and the request is certified. Therefore, the requested treatment is medically necessary.