

<b>Case Number:</b>	CM13-0058814		
<b>Date Assigned:</b>	06/09/2014	<b>Date of Injury:</b>	12/16/2011
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	10/28/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/26/2013

### 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 Occupational 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:

The patient is a 38-year-old female who has submitted a claim for cervicgia and lumbalgia associated with an industrial injury date of 12/16/2011. Medical records from 04/15/2013 to 08/12/2013 were reviewed and showed that patient complained of neck pain graded 8/10 radiating down bilateral upper extremities and low back pain graded 8/10 radiating down bilateral lower extremities. Physical examination revealed normal gait. Restricted cervical ROM and markedly restricted lumbar spine ROM was noted. Trigger point impedance imaging dated 04/15/2013 revealed lumbar myofascial pain syndrome. X-ray of the cervical and lumbar spine dated 03/17/2010 was unremarkable. MRI of the lumbar spine dated 09/09/2010 revealed L5-S1 retrolisthesis with tear or fissure in the posterior inferior annular fibers. Treatment to date has included unspecified visits of chiropractic treatment, unspecified visits of acupuncture, unspecified visits of physical therapy, TENS, LINT, and oral and topical pain medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CERVICAL/LUMBAR SPINE PHYSIOTHERAPY AND CHIROTHERAPY 1 TIMES 6:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine; Manual Therapy & Manipulation Page(s): 98-99, 59-60.

**Decision rationale:** According to pages 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Physical medicine guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. Manual therapy such as chiropractic care 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. The recommended initial therapeutic care for low back is a trial of 6 visits over 2 weeks, with evidence of objective functional improvement. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Chiropractic care is not recommended for other body parts other than low back. In this case, the patient has completed unspecified visits of physical therapy and chiropractic treatment. However, there was no documentation concerning the functional outcome from physical therapy and chiropractic treatment to support continuation of both treatments. Moreover, there was no discussion as to why the patient cannot self-transition into HEP. Therefore, the request for cervical/lumbar spine physiotherapy and chirotherapy 1 time a week for 6 weeks is not medically necessary.

**ACUPUNCTURE 1 TIMES 6 WEEKS:** Upheld

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

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

**Decision rationale:** According to the CA MTUS Acupuncture Medical Treatment Guidelines, acupuncture may be used as an option when pain medication is reduced or not tolerated or as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The guidelines allow the use of acupuncture for a frequency and duration of treatment as follows: time to produce functional improvement 3-6 treatments, frequency of 1-3 times per week, and duration of 1-2 months. Additionally, acupuncture treatments may be extended if functional improvement is documented. In this case, the patient has completed unspecified visits of acupuncture. However, there was no documentation concerning the functional outcome from previous acupuncture visits to support continuation of treatment. Moreover, there was no discussion stating that acupuncture will be used as an adjunct to physical rehabilitation as required by the guidelines. Therefore, the request for acupuncture 1 time a week for 6 weeks is not medically necessary.

