

<b>Case Number:</b>	CM13-0028579		
<b>Date Assigned:</b>	11/27/2013	<b>Date of Injury:</b>	10/10/2012
<b>Decision Date:</b>	01/15/2014	<b>UR Denial Date:</b>	09/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, 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 physician 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 underlying date of injury in this case is 10/10/2012. The primary diagnosis is a wrist sprain. A prior physician review notes that a request in this case of chiropractic two times a week for six weeks references the cervical spine, the bilateral shoulders, and bilateral elbows and wrists. The patient was noted to have complaints of pain in the neck, bilateral shoulders, bilateral elbows, and bilateral hand. Physical examination findings were noted to have included tenderness to palpation of the elbows as well as a positive Neer's test in the right shoulder. That initial physician review noted that there was no clearly defined significant objective functional improvement from past treatments. The current request, therefore, was felt to be not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic two times a week for six weeks for cervical spine, bilateral shoulders, elbows, and wrists:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines Section on Manual Therapy and Manipulation, page 58, states, "Forearm, Wrist, and Hand: Not recommended." Therefore, portions of the requested treatment are specifically not recommended by the treatment guidelines. In reference to the lower back, the guidelines state "Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, If return to work achieved then 1-2 visits every 4-6 months." These principles would apply as well to chiropractic in the cervical spine. This treatment request exceeds the guidelines and is not supported as medically necessary. Overall, this request is not medically necessary.