

<b>Case Number:</b>	CM13-0035395		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	12/12/2011
<b>Decision Date:</b>	05/13/2014	<b>UR Denial Date:</b>	10/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/17/2013

### 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, has a subspecialty in Pain Medicine, and is licensed to practice in Texas. 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 injured worker is a 53-year-old female who reported an injury on 12/12/2011, secondary to a fall. Current diagnoses include cervical spine strain, lumbar radiculopathy, left shoulder impingement syndrome, and right greater trochanteric bursitis. The injured worker was evaluated on 08/08/2013. The injured worker reported improvement in symptoms with TENS therapy. Physical examination revealed tenderness to palpation of the cervical spine with spasm and restricted range of motion, decreased range of motion of the left shoulder with positive impingement testing, and tenderness to palpation with spasm of the lumbar spine, restricted range of motion, and positive straight leg raising. Treatment recommendations included continuation of chiropractic treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CONTINUED CHIROPRACTIC CARE 3 X 4 TO THE THORACIC, CERVICAL, AND LUMBAR SPINE, LEFT SHOULDER, LEFT LOWER EXTREMITY:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines indicate that manual therapy and manipulation is recommended for chronic pain if caused by a musculoskeletal condition. Treatment for the low back is recommended as an option with a therapeutic trial of 6 visits over 2 weeks. Treatment for the lower extremity is not recommended. Treatment for the forearm, wrist, and hand is also not recommended. The current request for 12 sessions of chiropractic therapy exceeds Guideline recommendations. There is also no evidence of objective functional improvement as a result of previous chiropractic therapy. Based on the clinical information received, the request for continued chiropractic care 3 x 4 to the thoracic, cervical, and lumbar spine, left shoulder, left lower extremity is non-certified.