

<b>Case Number:</b>	CM13-0058460		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	07/08/2013
<b>Decision Date:</b>	08/13/2014	<b>UR Denial Date:</b>	11/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/27/2013

### 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 Licensed in Chiropractic, has a subspecialty in Chiropractic Sports physician 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 injured worker is a 49 year old female who was injured on 7/8/13. She has suffered overuse syndrome of the bialateral upper extremities to include the shoulders, elbows, wrists and hands as well as the neck due to her job duties. She has suffered from a prior carpal tunnel syndrome work injury for which she received an award 20 years ago. She appears to have had prior treatment of medications, physical therapy, and chiropractic care with no previous amounts given for each treatment or the patients response to each. On 11/20/13 NCV/EMG studies revealed chronic left C5 radiculitis. No MRI results were found in the medical records for any injured body part.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **CHIROPRACTIC 3XWK X 4WKS CERVICAL BILATERAL SHOULDERS/ELBOWS/WRISTS/HANDS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION Page(s): 58-59.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26 Page(s): 58-59.

**Decision rationale:** The medical doctor has not shown objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. In addition the amount of chiropractic treatment requested does not follow the MTUS Chronic Pain guidelines listed above. The requested treatment of 3 times per week for 4 weeks is not medically necessary. This request would most likely been accepted in the acute phase with ACOEM but these injuries are now Chronic and need to follow MTUS guidelines given above. As such, the request is not medically necessary.