

<b>Case Number:</b>	CM13-0059680		
<b>Date Assigned:</b>	02/26/2014	<b>Date of Injury:</b>	09/15/1997
<b>Decision Date:</b>	05/29/2014	<b>UR Denial Date:</b>	11/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2013

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Sports 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 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 71-year-old female who reported an injury on 09/15/1997, due to an unknown mechanism. The progress report dated 08/29/201, indicates that the patient reported neck, back, and knee pain. The physical exam findings revealed tenderness at the C2 and C7, and of the spinous process at T1, T6, and T12. An examination of the thoracic spine indicates the presence of increased tone in the trapezius bilaterally and rhomboids bilaterally with decreased range of motion. The treatment includes a myofascial release in the cervical region bilaterally, and coupled spinal adjustments. She was taught to perform cross crawls exercises, and is recommended for chiropractic care on an as needed basis. The request for authorization form was dated 10/23/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CONTINUED CHIROPRACTIC CARE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 178; 298-299, 153-154, Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION; Page(s): 58-60. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), NECK AND UPPER BACK CHAPTER AND BACK CHAPTER.

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

**Decision rationale:** The Chronic Pain Guidelines indicate that 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. It is a recommended option for therapeutic care for a trial of six (6) visits over two (2) weeks, with evidence of objective functional improvement, for a total of up to eighteen (18) visits over six to eight (6-8) weeks. The documentation includes reference to chiropractic care given, but there is no mention to the quantity or the frequency, and there is no reference to any evidence of objective functional improvement. In addition, the current request does not include quantity or the frequency of the proposed treatment. As such, the request is non-certified.