

<b>Case Number:</b>	CM14-0104913		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	10/17/2013
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	06/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/08/2014

### 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 licensed in Chiropractic and is Board Certified in Acupuncture 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 36 year old male who reported neck, mid-back, low back, bilateral shoulder, bilateral hand, bilateral elbow and bilateral wrist pain from injury sustained on 10/17/13 due to cumulative trauma. There were no diagnostic imaging reports to review. The patient is diagnosed with cervical/thoracic/lumbar spondylosis without myelopathy; carpal tunnel syndrome; tendinitis/bursitis of bilateral hands/wrists; lateral/medial epicondylitis of bilateral elbows. Patient has been treated with medication, therapy and chiropractic. The report dated 05/02/14 documented complaints of constant sharp, yet moderate neck pain. Patient also complains of constant moderate thoracic pain described as burning. In addition, the patient complains of intermittent moderate low back pain described as aching. Patient also complains of bilateral wrist/hand pain that is constant severe described as burning/sharp. Patient also complains of constant moderate shoulder pain and bilateral elbow pain that is described as deep and sharp. Per medical notes dated 05/23/14, patient was evaluated for functional improvement and he has completed 5 sessions since the last physical medicine request. The Patient improved in activities of daily living as he is now able to grab items, using both hand with less pain. The patient has increased range of motion of the lumbar spine; flexion from 25-72, extension 10-18, left lateral bending 15-25, right lateral bending 10-25. He also has increased range of motion of the right shoulder; flexion 85-120, extension 25-45; abduction 75-100 and adduction 10-45. Medical reports reveal evidence of changes and improvement in findings, revealing a patient who has achieved significant functional improvement to warrant additional treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic 3 times a week for 2 weeks of the thoracic spine, lumbar spine, cervical spine, bilateral shoulders, bilateral hands, bilateral elbows, and bilateral wrists: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation> Page(s): <58-59>.

**Decision rationale:** The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Manual Therapy and Manipulation. Pages 58-59 The Expert Reviewer's decision rationale: According to the MTUS guidelines, "Low Back: Recommended as an option. Therapeutic care- trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/ maintenance care- not medically necessary. Reoccurrences/ flare-ups- need to re-evaluate treatment success, if Return to Work (RTW) is achieved then 1-2 visits every 4-6 months. Treatment parameters from state guidelines. A) Time of procedure effect: 4-6 treatments. B) Frequency 1-2 times per week the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. C) Maximum duration: 8 weeks. At 8 weeks patient should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation has been helpful in improving function, decreasing pain and improving quality of life. Treatment beyond 4-6 visits should be documented with objective improvement in function." The patient has had prior chiropractic treatments with both symptomatic and functional relief. Per medical notes dated 05/23/14, "The patient had functional improvement in that he is now able to grab items, using both hands with less pain. The patient also had increased range of motion in the lumbar and shoulder region. Medical reports reveal evidence of changes and improvement in findings, revealing a patient who has achieved significant functional improvement to warrant additional treatment. Per guidelines, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work Therefore, 6 Chiropractic visits are medically necessary.