

<b>Case Number:</b>	CM14-0111580		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	04/10/2001
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	07/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2014

### 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 Certified in Physical Medicine & Rehab, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 44-year-old male who reported an injury on 04/10/2001 due to an unspecified mechanism of injury. The injured worker complained of back pain, neck pain, and shoulder pain which was described at the severity of 8-9/10 VAS. Past treatments included chiropractic therapy, massage therapy, and medications. The diagnoses included cervical sprain with radiculopathy, chest contusion of sprain, and possible chronic pericarditis. The physical examination dated 05/06/2014 of the cervical, thoracic, and lumbar spine revealed decreased range of motion with tendonitis noted to the left shoulder arm. The MSR's to the C5-6 and C6-7 revealed bilaterally 100% and the L3-4 and L5-S1 revealed 100% bilaterally. The sensory was within normal limits. Medications included a Terocin patch and Methoderm. The treatment plan included chiropractic therapy. The request for request for Authorization was not submitted within the documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chirotherapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

**Decision rationale:** The request for chiropractic therapy is not medically necessary. The California MTUS Guidelines state that chiropractic therapy for chronic pain if caused by musculoskeletal conditions is recommended. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in the functional improvement that facilitate progression of the patient's therapeutic exercise program and return to productive activities. The guidelines recommend a trial of 6 visits over 2 weeks, and with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks. The documentation indicated that the injured worker had already received chiropractic therapy; however, the documentation was not provided and the number of visits was not known. The clinician's notes also were vague. The physical examination looked to be within normal limits, indicating that the injured worker did not warrant any special circumstances that the injured worker would require additional chiropractic therapy. The request did not indicate the body part or the number of visits being requested. As such, the request is not medically necessary.