

<b>Case Number:</b>	CM14-0128235		
<b>Date Assigned:</b>	08/15/2014	<b>Date of Injury:</b>	06/05/2013
<b>Decision Date:</b>	09/12/2014	<b>UR Denial Date:</b>	08/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2014

### 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 licensed in Chiropractic 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:

According to the available medical records, this is a 56 year old male patient with chronic low back and upper extremities pain, date of injury 06/05/2013. Previous treatments include medications and casting for broken left wrist. Primary treating doctor's initial report dated 07/07/2014 revealed constant right shoulder pain that radiates to right elbow, numbness and tingling in the entire arm, on and off left wrist pain that radiates to the side of his forearm, on and off low back pain rated as 6/10, low back pain increased with bending and decreased when standing up. Exam of the thoracolumbar spine revealed tenderness to palpation with spasm of the lumbar paraspinal, ROM decreased in all ranges, positive sitting root and straight leg raise at 30 degrees on the right. Diagnoses include lumbar spine sp/st with radiculitis, right shoulder sp/st with clinical impingement, myospasm, right medical epidondylitis, right elbow sp/st, left wrist sp/st status post left wrist fracture and medication induced gastritis. The patient was returned to light work duties restriction.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic Therapy for the low back for a total of 6 sessions:** 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 Recommended for chronic pain if caused by musculoskeletal conditions. 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. 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. Recurrences/flares-up - Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines a. Time to produce effect: 4 to 6 treatments b. Frequency: 1 to 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. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life Page(s): 58-59.

**Decision rationale:** Reviewed of the medical records show that the request is actual for chiropractic treatment which include supervised physiotherapy 2x a week for 6 weeks; there is no specific physiotherapy listed. It is also recommended by CA MTUS guidelines to try an initial 6 chiropractic treatments over 2 weeks as therapeutic, with evidence of objective functional improvement, total up to 18 visits over 6-8 weeks. Therefore, without evidence of objective functional improvement and no specific physiotherapy request, it is not medically necessary.