

<b>Case Number:</b>	CM14-0036477		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	03/06/2002
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	03/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/25/2014

### 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 a licensed Doctor of Chiropractic 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 56-year-old female who reported an injury on 03/06/2012. The mechanism of injury was not provided for clinical review. The diagnosis included cervical/lumbar neuralgia, neuritis and radiculitis. Previous treatments include medication. Within the clinical note dated 01/30/2014, it was reported the injured worker complained of constant pain which radiated to the right lateral forearm and right thumb, index, with numbness. She rated her pain 6/10 in severity. On physical examination, the provider noted the injured worker's cervical range of motion was flexion at 46 degrees with pain and extension at 6 degrees with pain. The provider indicated sensation to the right C6 was decreased to light touch and pinprick. The injured worker had a positive Neutral Vertex Compression Test. The provider requested for 1 time a week for 4 weeks of manual therapy to decrease pain. However, the Request for Authorization was not submitted for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic treatments for the cervical and right shoulder, one time a week for four weeks.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy, page(s) 58 Page(s): 58.

**Decision rationale:** The injured worker complained of cervical pain. She noted her pain was constant and radiated to the lateral forearm, hand, thumb, index finger with numbness. She rated her pain 6/10 in severity. The California MTUS Guidelines recommend that manual therapy for chronic pain if caused by musculoskeletal conditions. The intended goal and effect of manual therapy is the achievement of positive symptomatic or objective measurable gains in a functional improvement that facilitates progression in the injured worker'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 and a total of up to 18 visits over 6 to 8 weeks. There is lack of documentation indicating the injured worker had significant objective functional improvement with the prior therapy. There is a lack of documentation regarding a complete physical examination to evaluate for decreased functional ability, decreased strength or flexibility. There is lack of documentation of the efficacy of the prior therapy. Therefore, the request is for chiropractic treatment for the cervical and right shoulder 1 time a week for 4 weeks is not medically necessary.