

<b>Case Number:</b>	CM13-0017799		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	04/10/2012
<b>Decision Date:</b>	03/03/2015	<b>UR Denial Date:</b>	08/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2013

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Chiropractic

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is presently a 47 year old female who suffered a work related injury on 04/10/2012. Diagnoses include cervical spine, strain and myofascial pain syndrome, thoraco-lumbar spine strain and sprain with right more than left sacroiliac joint sprain, right shoulder sprain with impingement, right wrist sprain with DeQuervain's tenosynovitis, bilateral knee sprain and right ankle sprain with plantar calcaneal spur and plantar fasciitis. Treatment has included medications, aquatic therapy, chiropractic sessions, and Orthostim4 Unit. A physician's progress note dated 07/23/2013 documents the injured worker complains of bilateral shoulder pain with decreased range of motion, right wrist and lumbar back pain. She continues to have difficulty with activities of daily living, such as getting dressed and grooming. She has bilateral shoulder impingement, and she has tenderness in the paraspinal area with spasms. In a progress note dated 7/2/2013 it is documented that despite conservative measures, her low back and bilateral lower extremity symptoms persisted. The request is for 6 chiropractic treatments between 08/02/2013 and 10/31/2013. Utilization Review dated 08/02/2013 non-certified the request for 6 chiropractic treatments between 08/02/2013 and 10/31/2013, citing California Chronic Pain Medical Treatment Guidelines-Manual therapy and manipulation. Manual therapy and manipulation for chronic pain is recommended if it is caused by musculoskeletal conditions. The goal is aimed at positive symptomatic or objective measurable gain in functional improvement that facilitates progression in the patient's therapeutic exercise program and return to productive activities. With evidence of functional improvement, a maximum of 18 visits over six to eight weeks is recommended. In cases of recurrences or flare-ups 1-2 visits every 4-6 months is

recommended for a return to work status. Additional chiropractic care does not seem indicated for this injured worker. The most recent progress report noted that despite conservative methods, her low back and bilateral lower extremity symptoms persisted. There has not been functional improvement to warrant additional chiropractic care beyond the previously certified 22 visits.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **6 chiropractic treatments between 8/2/13 and 10/31/13: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter

**Decision rationale:** The patient has received prior chiropractic care. The current request is for 6 additional sessions of chiropractic care to the lumbar spine. The ODG Low Back Chapter for Recurrences/flare-ups states : "Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care." MTUS-Definitions page 1 defines functional improvement as a "clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.11; and a reduction in the dependency on continued medical treatment." The PTP describes some Improvements with treatment but no objective measurements are listed. Stating that the pain has decreased and range of motion increase does not provide objective functional improvement data as defined in The MTUS. The records provided by the primary treating chiropractor do not show objective functional improvements with ongoing chiropractic treatments rendered. The chiropractic care records are not present in the records provided. I find that the 6 chiropractic sessions requested to the lumbar spine to not be medically necessary and appropriate.