

<b>Case Number:</b>	CM15-0007400		
<b>Date Assigned:</b>	01/22/2015	<b>Date of Injury:</b>	09/15/1997
<b>Decision Date:</b>	03/17/2015	<b>UR Denial Date:</b>	12/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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:

The injured worker is a 68 year old female, who sustained an industrial injury on 09/15/1997. She has reported neck, arm, shoulder and back pain. The diagnoses have included carpal tunnel syndrome, chronic cephalgia, cervicgia with shoulder and arm pain, thoracic radiculitis, and lumbosacral strain/sprain. Treatment to date has included medications and chiropractic treatment. A progress note from the treating physician, dated 11/28/2014, documented a follow-up visit with the injured worker. The injured worker reported a flare-up of radiating arm pain with paresthesia numbness and weakness; shoulder, upper back and neck pain/stiffness; lower back/pelvic pain; pain is rated 8/10 on the visual analog scale; and neck and upper extremity movements exacerbate symptoms and limit all activities of daily living. Objective findings included tenderness to palpation of the subocciput-C2, costotransverse T3-4 and parascapular muscles bilaterally, and the dorsal and volar wrists; mildly restricted cervical range of motion with pain in rotation and extension. The treatment plan has included chiropractic manipulation and physiotherapy; continuation of over-the-counter medications and prescribed home exercises; and follow-up evaluation. On 12/22/2014 Utilization Review noncertified a prescription for Chiropractic x 3. The CA MTUS: Chronic Pain Medical Treatment Guidelines was cited. On 01/05/2015, the injured worker submitted an application for IMR for review of a prescription for Chiropractic x 3.

### IMR ISSUES, DECISIONS AND RATIONALES

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

### **Chiropractic X3:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neck & Upper Back, Low Back, Shoulder, Wrist, Hand & Forearm Chapters Page(s): 58-60. Decision based on Non-MTUS Citation Neck & Upper Back, Low Back, Shoulder, Wrist, Hand & Forearm Chapters

**Decision rationale:** This is a chronic injury case with ongoing care provisions in place. The patient has injured multiple body regions. The requested number of chiropractic care treatments do not specify the body region(s) for which the care is being requested. The ODG Neck & Upper Back, Shoulder and Low Back Chapters for Recurrences/flare-ups state: "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. Range of motion measurements for all body regions are not listed. I find that the 3 chiropractic sessions requested to the neck, upper back, lower back, shoulders and bilateral upper extremities to not be medically necessary and appropriate.