

<b>Case Number:</b>	CM15-0132170		
<b>Date Assigned:</b>	07/20/2015	<b>Date of Injury:</b>	10/20/2010
<b>Decision Date:</b>	08/14/2015	<b>UR Denial Date:</b>	06/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/08/2015

### 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: Chiropractor, Oriental Medicine

### 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 37-year-old female, who sustained an industrial injury on 10/20/2010. The mechanism of injury was not noted. The injured worker was diagnosed as having thoracic spine pain, lumbago, rotator cuff syndrome, and myalgia-myositis. Treatment to date has included chiropractic sessions. Currently (5/15/2015), the injured worker complains of thoracic spine pain with radiation to the left shoulder, lumbago, and shoulder pain radiating down the left upper arm. Pain was rated 7/10 and consistent for many months. The symptoms were documented as present since the date of injury. Exam noted myofascial pain, tenderness, and no change in progress. Current medication regimen was not documented. Work status was not noted. The treatment plan included chiropractic therapy, twice weekly x 3 months.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic 2x/ week for 3 months for the low back and left shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CA Medical Treatment Utilization Schedule (MTUS): The American College of Occupational and Environmental Medicine (ACOEM); 2nd Edition, 2004; CHRONIC PAIN MEDICAL TREATMENT GUIDELINES; Title 8, California Code of Regulations, section 9792.20 et seq. Effective July 18, 2009; 2009; 9294.2; pages 58/59: manual therapy and manipulation Page(s): 58/59.

**Decision rationale:** The UR determination of 6/3/15 denied the request for additional Chiropractic care, 2xs per weeks for 3 months to the patient lower back, citing CAMTUS Chronic Treatment Guidelines. The patient's history of treatment reflects prior course of manipulation directed to lower back prior to the 5/15/15 request for additional care. The reviewed medical records did not support the medical necessity for additional manipulation in the absence of documented evidence of functional improvement or compliance with CAMTUS Chronic Treatment Guidelines. "Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam. This request is not medically necessary.