

<b>Case Number:</b>	CM15-0022704		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	10/21/1996
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	02/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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 76 year old female who sustained an industrial related injury on 1/15/01. The injured worker had complaints of limited range of motion of the neck and arms with associated muscle spasms. Headaches and tingling with numbness in the cervical region as well as weakness to bilateral arms was noted. Diagnoses included cervical musculoligamentous injury and status post cervical fusion. Treatment included a cervical epidural steroid injection. Medications included Duragesic patches and Dilaudid. The treating physician requested authorization for a chiropractic referral for 2x6 weeks. The request was non-certified on 2/4/15. The utilization review physician cited the Medical Treatment Utilization Schedule guidelines and noted a trail of H-wave should be first assessed prior to considering additional therapeutic intervention. Therefore the request was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Referring Patient to Chiropractor 2x6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58, Postsurgical Treatment Guidelines Page(s): Neck & Upper Back Chapter. Decision based on Non-MTUS Citation ODG Neck & Upper Back Chapter, Manipulation Section/MTUS Definitions

**Decision rationale:** The records provided for review show no evidence of prior chiropractic care for this patient. The patient is status post-surgery for her neck (2001). The MTUS Post-Surgical Treatment Guidelines recommends 16 visits of physical medicine treatment over 8 weeks for cervical fusion/discectomy. It is unclear from the records provided if the patient has completed the 16 sessions of post-surgical physical medicine treatments. The surgery occurred 14 years and the post-surgical physical medicine time of 8 weeks have passed. The MTUS Chronic Pain Medical Treatment Guidelines recommends additional manipulative care with evidence of objective functional improvement. The ODG Neck & Upper 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." The same section recommends a trial of 6 sessions over 2 weeks. The 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. If this is a request for additional sessions or if this is a request for an initial trial of 12 sessions of chiropractic care, the requested number of visits far exceed the recommended number. The records provided by the primary treating physician do not show objective functional improvements with ongoing chiropractic treatments rendered. Past chiropractic treatment records are not present in the records provided. I find that the 12 chiropractic sessions requested to the cervical spine to not be medically necessary and appropriate.