

<b>Case Number:</b>	CM15-0218160		
<b>Date Assigned:</b>	11/10/2015	<b>Date of Injury:</b>	09/09/2009
<b>Decision Date:</b>	12/29/2015	<b>UR Denial Date:</b>	10/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2015

### 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

### 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 sustained an industrial injury on 09-09-2009. A review of the medical records indicated that the injured worker is undergoing treatment for cervical spine musculoligamentous injury, bilateral shoulder impingement, anxiety, depression and gastritis secondary to medications. The injured worker is status post lumbar interbody fusion in 2012. According to the treating physician's progress report on 09-23-2015, the injured worker continues to experience stiffness, pain and lack of motion in the neck and shoulders associated with upper extremity weakness and numbness and tingling, right side greater than left. Examination demonstrated paravertebral and upper trapezius muscle tenderness and spasm bilaterally with decreased range of motion. Maximum foraminal compression and shoulder depression tests were positive bilaterally. Cervical distraction test was negative bilaterally. The upper extremity evaluation noted sensation and deep tendon reflexes were intact with positive tenderness to palpation at the acromioclavicular joint, subacromial space, bicipital groove, capsule, soft tissue and osseous structure. Right shoulder motor strength was documented as 4 out of 5. Range of motion was decreased with pain at abduction, forward flexion, extension and internal and external rotation. Apley's Scratch, supraspinatus, impingement and Yergason's tests were positive on the right. Speed's test was negative on the right. The thoracolumbar paravertebral musculature was positive bilaterally for tenderness and spasm. Prior treatments have included diagnostic testing, physical therapy (6 sessions to the right shoulder), functional restoration program (FRP) completed in 09-2015 and medications. Current medications were listed as Gabapentin, Ibuprofen and Omeprazole. Treatment plan consists of the current request for chiropractic therapy for the neck and bilateral shoulders Qty: #6. On 10-09-2015, the Utilization Review determined the request for chiropractic therapy for the neck and bilateral shoulders Qty: #6 was not medically necessary.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic treatment for neck and bilateral shoulders Qty: 6:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The medical necessity for the requested 6 additional chiropractic treatments was not established. The claimant had undergone extensive course of chiropractic treatment and then enrolled in a functional restoration program and completed 20 sessions through August 2015. The claimant reportedly achieved overall functional improvement. Approximately 5 weeks later, the claimant returned to the office of [REDACTED] for continued complaints and felt that 6 visits of chiropractic therapy prior to permanent and stationary status are necessary. This is not a sufficient rationale for additional treatment. This claimant had undergone a sufficient course of chiropractic treatment prior to the functional restoration program. The need for additional treatment following completion of the FRP was not established. Therefore, the request is not medically necessary. The MTUS chronic pain treatment guidelines, page 58, give the following recommendations regarding manipulation: "Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks."