

<b>Case Number:</b>	CM15-0054988		
<b>Date Assigned:</b>	03/30/2015	<b>Date of Injury:</b>	07/21/2011
<b>Decision Date:</b>	05/08/2015	<b>UR Denial Date:</b>	03/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/23/2015

### 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 36 year old female patient who sustained an industrial injury on 07/21/2011. A primary treating office visit dated 07/27/2011 reported the patient with subjective complaint of pain and swelling. She is diagnosed with right lateral epicondylitis, sprain shoulder/arm; sprain thoracic region and sprain lumbar region. Recommending physical therapy treatment. Prior treatment to include: physical therapy, cold/heat application. The worker is to return to modified work duty for a three day time period. Another primary treating office visit dated 09/25/2014 reported the patient unable to make this appointment and she is asking that her medications be refilled. Current medications are: right shoulder impingement syndrome; right elbow medial epicondylitis; right wrist pain; lumbar sprain/strain, and lumbar radiculopathy. The plan of care involved advising the patient to continue seeing her primary care physician. Prescription noted refilled. She is to return in 4 weeks for follow up.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic Treatments, for Lumbar Spine, Right Shoulder, Right Elbow, Right Wrist - 3 times weekly for 6 weeks (18): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-59.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : 2009; 9294.2; pages 58/59: manual therapy and manipulation Page(s): 58/59.

**Decision rationale:** The UR determination of 3/6/15 denied additional Chiropractic care, 18 sessions citing CAMTUS Chronic Treatment Guidelines. The patient was reported to be status post 14 sessions of Chiropractic care with no clinical evidence of functional improvement as required by referenced CAMTUS Guidelines or support for any manipulation of the patient upper extremity. The reviewed records fail to support the medical necessity for continued care, 18 sessions of Chiropractic manipulation; care exceeds guidelines, is not supported by evidence of prior functional improvement and manipulation is not recommended for upper extremity. Therefore the request is not medically necessary.