

<b>Case Number:</b>	CM15-0081731		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	02/16/2013
<b>Decision Date:</b>	06/05/2015	<b>UR Denial Date:</b>	04/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/28/2015

### 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 66 year old male, who sustained an industrial injury on 02/16/2013. He reported the gradual development of pain to the neck, right shoulder, and right arm with associated symptoms of numbness and weakness to the hand. The injured worker was diagnosed as having cervical spine musculoligamentous strain/sprain with radiculitis, rule out cervical spine discogenic disease, lumbar spine disc protrusion with radiculitis, left shoulder impingement syndrome, left adhesive capsulitis, left shoulder rotator cuff tear, left shoulder labral lesion, left shoulder failure of conservative care, status post left shoulder surgery with residual, bilateral carpal tunnel syndrome, bilateral trigger fingers, and left trochanteric bursitis. Treatment to date has included magnetic resonance imaging of the lumbar spine, magnetic resonance arthrogram of the left shoulder, electromyogram with nerve conduction velocity, chiropractic therapy, physical therapy, and above listed procedure. In a progress note dated 03/12/2015 the treating physician reports complaints of pain to the neck that radiates along the pattern of the bilateral cervical five and cervical six dermatomes. The injured worker also has complaints of pain to the lower back and left shoulder along with radicular pain and numbness to the right wrist and left wrist. The pain to the neck is rated a five out of ten on a visual analog scale of zero to ten which is an increase from a three out of ten from previous visit. The pain to the back is rated a three out of ten with no change from prior visit. The pain to the left shoulder is rated a five out of ten which was noted to be a decrease from a six out of ten from the prior visit, and the pain to the bilateral wrists was rated a five out of ten which was noted to be an increase from a four out of ten from the previous visit. The treating physician requested chiropractic therapy of the cervical spine, lumbar spine and left shoulder

two times a week for six weeks with the treating physician noting that prior chiropractic therapy has been helpful and noted that the injured worker is experiencing a flare-up of symptoms.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Chiropractic therapy 2x6 weeks cervical spine, lumbar spine, left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58. Decision based on Non-MTUS Citation ODG Neck & Upper Back, Low Back and Shoulder Chapters, Manipulation Sections/MTUS Definitions page 1.

**Decision rationale:** The patient has received chiropractic treatment for his injuries. The chiropractic treatment records in the materials submitted for review do not show objective functional improvement with the past chiropractic care rendered. The MTUS Chronic Pain Medical Treatment Guidelines and the ODG Neck and Upper Back and Low Back Chapters recommends additional chiropractic care with evidence of objective functional improvement, 1-2 sessions every 4-6 months. The ODG Shoulder Chapter recommends a limited number of manipulative care, 9 sessions over 8 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." The ODG Low Back Chapter and The Chronic Pain Medical Treatment Guides recommend additional chiropractic care for flare-ups "with evidence of objective functional improvement." No objective functional gains have been evidenced with the past rendered chiropractic care. The number of sessions requested far exceed The MTUS recommended number. I find that the 12 additional chiropractic sessions requested to the cervical spine, lumbar spine and left shoulder to not be medically necessary and appropriate.