

<b>Case Number:</b>	CM14-0183006		
<b>Date Assigned:</b>	11/07/2014	<b>Date of Injury:</b>	05/09/2002
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	10/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 52-year-old female with a 5/9/02 date of injury. At the time (9/19/14) of request for authorization for Chiropractic therapy (sessions) quantity 12.00 and Prolotherapy to neck (sessions), there is documentation of subjective (neck pain) and objective (tenderness over the cervical paraspinal musculature with spasm, decreased cervical range of motion, and normal motor examination) findings, current diagnoses (degeneration of cervical intervertebral disc and displacement of cervical intervertebral disc without myelopathy), and treatment to date (epidural steroid injection, previous chiropractic therapy treatments, and 1 previous prolotherapy treatment). Medical report identifies that previous chiropractic therapy and prolotherapy treatments provided significant pain relief. Regarding chiropractic therapy, the number of previous chiropractic therapy sessions cannot be determined.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic Therapy (sessions) quantity 12.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manipulations Manual Therapy Page(s): 56-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & manipulation Page(s): 58. Decision based on Non-MTUS Citation Other Medical

Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS reference to ACOEM identifies documentation of objective improvement with previous treatment, functional deficits, functional goals, and a statement identifying why an independent home exercise program would be insufficient to address any remaining functional deficits, as criteria necessary to support the medical necessity of additional chiropractic treatment. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. In addition, MTUS Chronic Pain Medical Treatment Guidelines supports a total of up to 18 visits over 6-8 weeks. Within the medical information available for review, there is documentation of diagnoses of degeneration of cervical intervertebral disc and displacement of cervical intervertebral disc without myelopathy. In addition, there is documentation of previous chiropractic therapy treatments, functional deficits, and functional goals. However, there is no documentation of the number of previous treatments to determine if guidelines has already been exceeded or will be exceeded with the additional request and, if the number of treatments have exceeded guidelines, remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines. In addition, despite documentation that previous chiropractic therapy treatments provided significant pain relief, there is no documentation of objective improvements. Therefore, based on guidelines and a review of the evidence, the request for Chiropractic therapy (sessions) quantity 12.00 is not medically necessary.

**ProloTherapy to neck (sessions):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Sclerotherapy (prolotherapy) Page(s): 105.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Prolotherapy Page(s): 99-100.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that prolotherapy is not recommended and that the effects of prolotherapy did not significantly exceed placebo effects. Therefore, based on guidelines and a review of the evidence, the request for Prolotherapy to neck (sessions) is not medically necessary.