

<b>Case Number:</b>	CM14-0218124		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	08/21/2013
<b>Decision Date:</b>	03/05/2015	<b>UR Denial Date:</b>	12/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2014

### 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. 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 47 year old male with a date of injury as 08/21/2013. The cause of the injury was not included in the documentation received. The current diagnoses include cervical strain, lumbar strain, partial rotator cuff tear-right shoulder, right elbow partial thickness tear, and right ankle sprain/strain. Previous treatments include medications, physical therapy, and chiropractic therapy. Primary treating physician's reports dated 01/21/2014 through 10/31/2014, secondary treating physician progress reports dated 01/09/2014 and 02/04/2014, qualified medical exam preliminary report dated 05/15/2014, and work status reports dated 05/27/2014 through 12/2/2014 were included in the documentation submitted for review. Report dated 10/31/2014 noted that the injured worker presented with complaints that included cervical spine, lumbar spine, bilateral shoulder, right elbow, right wrist, and right ankle pain. Physical examination revealed decreased range of motion in the cervical spine, lumbar spine, right shoulder, right elbow, and right ankle, tenderness over the paraspinal muscles, acromioclavicular joint, medial epicondyle, and medial and lateral malleoli and the dorsal aspect of the foot. Testing performed revealed positive Spurling's on the right, positive Kemp's sign, positive Hawkin's impingement and Neer's impingement on the right, positive cubital tinel's sign in the right elbow. The physician noted that the injured worker continues to have weakness and continued pain affecting the right ankle. Treatment plans included continued therapy for the neck, back, right shoulder, and right wrist, and request fro physical therapy for the right ankle. The utilization reviewer noted that the injured worker had completed 24 prior sessions of chiropractic therapy, but there were no progress notes from the prior chiropractic treatments

included in the documentation submitted for review. The injured worker is on temporary total disability. The utilization review performed on 12/17/2014 non-certified a prescription for 12 sessions of chiropractic therapy based on the previously authorized 24 sessions for lumbar manipulation and lack of diagnosis for frozen shoulder. The reviewer referenced the California MTUS and ACOEM in making this decision.

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

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

#### **12 Sessions of Chiropractic Therapy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Low Back and Shoulder Chapters Page(s): Manipulation Sections. Decision based on Non-MTUS Citation Low Back and Shoulder Chapters

**Decision rationale:** The UR reviewer in indicates that there has been certification for 24 sessions of chiropractic care in this case. There is no evidence of prior chiropractic care from the records provided for review. The MTUS ODG Low Back Chapter recommends a trial of 6 sessions of chiropractic care for the low back to be rendered over 2 weeks. The same section 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." 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 Shoulder Chapter recommends a trial of chiropractic treatment. Regardless of the existence of past chiropractic care or the non-existence of prior chiropractic care, the number of sessions requested to the low back and shoulder far exceed the ODG and MTUS recommendations (Chronic Pain Medical Treatment Guides).I find that the 12 chiropractic sessions requested to the lumbar spine and shoulder to not be medically necessary and appropriate.