

<b>Case Number:</b>	CM15-0114040		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	10/17/2006
<b>Decision Date:</b>	07/28/2015	<b>UR Denial Date:</b>	06/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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 42 year old female who sustained an industrial injury on 10/17/2006. Diagnoses include head pain, lumbosacral musculoligamentous strain/sprain with radiculitis, rule out lumbosacral spine discogenic disease, right shoulder sprain/strain, right elbow strain/sprain, right elbow lateral epicondylitis, right wrist strain/sprain, right out right wrist carpal tunnel syndrome, right hand strain/sprain, old healed non-union right 5th index fracture, per x ray dated 03/02/2015, and status post left knee surgery with residuals. Treatment to date has included diagnostic studies, medications, and 19 sessions of physical therapy, injections, Extracorporeal Shockwave therapy to the left knee, Functional therapy evaluation, and manipulation therapy. A physician progress note dated 05/11/2015 documents the injured worker complains of headaches, as well as pain in the lower back, right shoulder and left knee. She also has pain and numbness in the right wrist and hand. She rates her headaches as 7 out of 10 on the Visual Analog Scale which has remained the same since his last visit. Her lower back is rated as 8 out of 10 which has increased from 6 out of 10 since his last visit, and her right wrist pain is rated 8 out of 10 which has remained the same. Her left knee is rated 8 out of 10 which has remained the same. Her cervical spine has grade 3-4 tenderness to palpation over the paraspinal muscles, which has increased from grade 3 on the last visit and 2-4 palpable spasm, which has decreased from 4 on the last visit. Cervical compression is present and trigger points are present. Her lumbar spine has grade 3 tenderness to palpation over the paraspinal muscle which has remained the same since her last visit and 2-4 palpable spam which has remained the same. There is restricted range of motion. Straight leg raise test is positive bilaterally. Her right

shoulder, right elbow, right wrist, right hand and left knee are tender to palpation. She indicated that her function and activities of daily living have improved with physical therapy. She has received chiropractic treatment in the past. The treatment plan includes topical medication, Ibuprofen, a right wrist brace, a urine toxicology testing, and she is pending authorization for right hand surgery consultation. Treatment requested is for Chiro for evaluation and treatment of the lumbar spine, right shoulder and right wrist, twice weekly for six weeks.

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

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

**Chiro for evaluation and treatment of the lumbar spine, right shoulder and right wrist, twice weekly for six weeks: Upheld**

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

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

**Decision rationale:** The patient has received chiropractic care for her injuries in the past. The past chiropractic treatment notes are not present in the materials provided for review. The total number of chiropractic sessions provided to date are unknown and not specified in the records provided for review. Regardless, the treatment records submitted for review do not show objective functional improvement with past chiropractic care rendered, per MTUS definitions. The MTUS Chronic Pain Medical Treatment Guidelines recommends additional care with evidence of objective functional improvement. The ODG Low Back Chapter also recommends 1-2 additional chiropractic care sessions over 4-6 months with evidence of objective functional improvement. The MTUS and ODG do not recommend manipulation for the wrist. The ODG does recommend a limited number of manipulative care sessions for the shoulder 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." There have been no objective functional improvements with the care in the past per the treating physician's progress notes reviewed. I find that the 12 additional chiropractic sessions requested to the lumbar spine, right wrist and is not medically necessary or appropriate.