

Case Number:	CM13-0047425		
Date Assigned:	12/27/2013	Date of Injury:	01/28/2006
Decision Date:	02/27/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	11/01/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Licensed in Chiropractic Care, and is licensed to practice in Texas. 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 physician 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:

The patient is a 55-year-old who reported a work related injury on 01/28/2006, specific mechanism of injury not stated. The patient presents for treatment of the following diagnoses status post left hand disarticulation and amputation, left median nerve neuroma with phantom pain, left shoulder impingement syndrome/rotator cuff tendinitis with tear, status post left ankle fracture, severe psychophysiological disruption and insomnia. The clinical note dated 09/10/2013 reported the patient was seen under the care of [REDACTED]. The provider documented the patient reported continued complaints of pain to the low back radiating to the bilateral lower extremities, as well as cervical spine pain and headaches. The provider documented a request authorization for therapy 3 times a week for 6 weeks for the cervical spine, lumbar spine, left shoulder, renewal of the patient's medication regimen to include Norco, Ultram, Anaprox.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic care, twice per week for five weeks, for the left arm/wrist prosthetic: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: The clinical documentation submitted for review fails to evidence the specific rationale for the request of chiropractic manipulation at this point in the patient's treatment to the left upper extremity. The clinical notes document the patient has utilized 23 sessions of occupational therapy, 30 sessions of physical therapy. The clinical notes failed to document a specific rationale for the requested manipulation at 2 times a week for 5 weeks to the left arm/wrist. In addition, the Chronic Pain Medical Treatment Guidelines indicates trial of 6 visits over 2 weeks with evidence of objective functional improvement is supported for the low back. However, manipulation is not recommended for the forearm, wrist or hand. .The request for chiropractic care, twice per week for five weeks, for the left arm/wrist prosthetic is notmedically necessary or appropriate.