

Case Number:	CM13-0054512		
Date Assigned:	12/30/2013	Date of Injury:	10/21/2012
Decision Date:	03/26/2014	UR Denial Date:	11/07/2013
Priority:	Standard	Application Received:	11/19/2013

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 Board Certified in Physical Medicine & Rehabilitation 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 35-year-old male who reported injury on 10/21/2012. The mechanism of injury was noted to be repetitive motion. The documentation submitted with the review indicated that the patient had tenderness to palpation at T4-7, L3-S1, volar carpal ligament, and positive myospasms of the thoracic spine, lumbar spine, and bilateral wrist pain and end range of motion. The right wrist had a ganglion cyst of the lunate, left wrist ganglion cyst of the trapezoid and capitate, and the thoracic spine had a 2 mm disc at T5-6 and a 3 mm disc at T6-7. The diagnosis was noted to include left wrist with ganglion cyst and right wrist with ganglion cyst. The treatment plan was for chiropractic treatment 2 times a week x4 weeks for the right wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Osteopathic treatment right wrist: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58-59.

Decision rationale: The Physician Reviewer's decision rationale: California MTUS states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal

conditions. Treatment is not recommended for the wrist, & hand. Clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant nonadherence to guidelines recommendations, as California MTUS does not recommend manual therapy for the wrist and the hand. Additionally, there was a lack of documentation per the submitted request for the quantity of sessions being requested. Given the above and the lack of documentation of exceptional factors, the request for osteopathic treatment of the right wrist is not medically necessary.