

<b>Case Number:</b>	CM14-0111448		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	08/30/2002
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	07/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/16/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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:

The injured worker is a 63 year-old-female who reported an injury on 08/30/2002 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to her bilateral upper extremities. The injured worker was evaluated on 06/19/2014 it was noted that the injured worker had pain complaints of the left upper extremity. Objective physical findings included restricted range of motion of the bilateral shoulders with reduced grip strength on the left when compared to the right. It was noted that the injured worker had an x-ray of the left shoulder that noted degenerative changes. The injured worker's diagnoses included Left Shoulder Sprain/Strain, Left Trapezius Spasm/Strain, and Left Hand Sprain/Strain. A request was made for x-rays of the bilateral wrists and hands and chiropractic care.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro bilateral wrist x-ray, quantity two.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Forearm, Wrist and Hand Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 168-169. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand Chapter, Radiographs.

**Decision rationale:** The American College of Occupation and Environmental Medicine recommend X-rays for acute trauma to the bilateral wrists. Official Disability Guidelines recommend radiographs for chronic wrist pain for an initial study when there is no specific area of pain and the pain is considered generalized. The clinical documentation submitted for review does not provide any support for an X-ray of the bilateral wrists. There is no documentation of acute trauma or a significant change in the injured worker's clinical presentation to support the need for an X-ray secondary to chronic pain. The clinical documentation did not adequately address the injured worker's pain location in the right wrist. Therefore, the retrospective request for bilateral wrists X-rays is not medically necessary or appropriate.

**Retro bilateral hand x-ray, quantity two.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Forearm, Wrist and Hand Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 169-171.

**Decision rationale:** The American College of Occupational and Environmental Medicine recommend X-rays for forearm, wrist and hand injuries when there is acute trauma and suspicion of a fracture. The clinical documentation submitted for review does indicate that this is a chronic injury and there has not been a significant change in the injured worker's clinical presentation to support the need for an X-ray. As such, the retrospective request for the bilateral x-rays quantity 2 is not medically necessary or appropriate.

**Retro chiropractic physical rehabilitation one to three times per week for two weeks.:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines: Manual Therapy and Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine and Manual Therapy and Manipulation Page(s): 98-99, 58.

**Decision rationale:** California Medical Treatment Utilization Schedule does recommend up to 10 visits for Chronic Myofascial and Neuropathic Pain. The clinical documentation indicates that the injured worker has not had any previous skilled physical therapy. However, the request as it is submitted does not clearly identify a body part. California Medical Treatment Utilization Schedule does not recommend manual therapy for the wrists and hands. As the injured worker has multiple pain generators the appropriateness of the request cannot be determined. As such, the retrospective request for Chiropractic Physical Rehabilitation 1 to 3 times per week for 2 weeks is not medically necessary or appropriate.

