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| Case Number: | CM14-0164624 | | |
| Date Assigned: | 10/09/2014 | Date of Injury: | 05/19/2010 |
| Decision Date: | 11/10/2014 | UR Denial Date: | 09/08/2014 |
| Priority: | Standard | Application Received: | 10/06/2014 |

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 Orthopedic Surgery and is licensed to practice in California. 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:

This 52-year-old female packer sustained an industrial injury on 5/19/10. Injury occurred while placing a 35-pound container on an overhead rack and also due to repetitive work duties. Past surgical history was positive for right wrist arthroscopy with synovectomy and scapholunate ligament thermal shrinkage on 2/25/11, and release of the right first and second dorsal extensor compartments on 9/30/11. The patient underwent right wrist arthroscopy with synovectomy, scapholunate ligament repair, and right posterior interosseous neurectomy on 1/4/13. Debridement of radiocarpal synovitis, percutaneous K-wire fixation of the scaphoid, lunate and capitate, and dorsal capsulodesis were also performed. She subsequently developed scapholunate widening and underwent excision of the right scaphoid with four-corner fusion using right iliac crest bone graft on 6/26/13. She began post-op occupational therapy on 8/7/13. The 11/7/13 orthopedic report documented imaging findings of a solid four-corner fusion with ulnar +3 mm variant and some deformity of the sigmoid notch. Additional treatment was recommended to include continued activity modification and use of a wrist splint for discomfort. No further surgery or therapy was recommended. The 6/13/14 right wrist x-ray report documented status post open reduction and internal fixation with a metallic prosthesis seen in the capitate, hamate, triquetrum, and lunate bones and a metallic prosthesis in the distal radius. The navicular bone was surgically absent. There was no evidence of acute fracture or destructive changes present. The 8/8/14 chiropractic progress report cited subjective complaints of constant grade 8/10 right wrist post-surgical pain and grade 7/10 low back pain radiating to the left knee. Pain was increased with lifting over 5 pounds and prolonged sitting/standing. Physical exam findings documented moderate right wrist and low back tenderness to palpation, well-healed right wrist and forearm scarring, positive orthopedic tests, and decreased range of motion with pain. The diagnosis was right wrist post-op pain and lumbar discopathy per CT scan. The treatment plan

recommended continued chiropractic care, biofeedback, and exercises one time per week for 6 weeks, acupuncture two times per week, and referral for psychological and orthopedic consult. The patient was off work. The 9/8/14 utilization review denied the request for chiropractic treatment to the right wrist as there was no guideline support for manipulation of the wrist, the number of postsurgical treatment visits was not documented, and clinical evidence with prior post-op treatment was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment for the right wrist, 1 time a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation; Physical medicine Page(s): 9, 98-99.

Decision rationale: The California MTUS guidelines generally support the use of manual therapy and manipulation for the treatment of chronic pain caused by musculoskeletal conditions. However, the guidelines do not recommend the use of manipulative treatment in the treatment of forearm, wrist & hand complaints. MTUS physical medicine guidelines state that all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. Guideline criteria have not been met. This patient completed a course of post-op hand therapy with release to home management as of 11/7/13. The current request for chiropractic treatment to the right wrist appears directed toward pain reduction. There is no specific functional deficit to be addressed by chiropractic; improvement in range of motion following fusion is not a reasonable treatment goal. There is no clear indication of how much chiropractic treatment has been provided, and what, if any, objective functional benefit has been achieved. There is no indication why a home exercise program would be insufficient. There is no compelling reason to support the medical necessity of chiropractic treatment of the right wrist in the absence of guideline support. Therefore, this request is not medically necessary.