

Case Number:	CM14-0069085		
Date Assigned:	07/14/2014	Date of Injury:	07/13/2009
Decision Date:	10/07/2014	UR Denial Date:	05/13/2014
Priority:	Standard	Application Received:	05/14/2014

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 Occupational Medicine, 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:

Patient is a 41 year-old female with date of injury 08/04/2013. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 05/21/2014, lists subjective complaints as pain in the neck with radicular symptoms to the left arm. Objective findings: Left wrist range of motion was decreased in all planes due to pain. Tinel's sign was positive on the left for carpal tunnel and Phalen's sign was positive on the left for carpal tunnel. Diagnosis: 1. Cervical strain/sprain, herniated cervical disc with radiculitis 2. Left shoulder strain/sprain 3. Left wrist strain/sprain 4. Left hand strain/sprain, carpal tunnel syndrome. Treatment to date has including 12 sessions of physical therapy and wrist bracing.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy for 4 weeks unspecified side frequency per week.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The Application for Independent Medical Review states the request as, unknown additional chiropractic therapy for submitted diagnosis shoulder pain (unspecified side) for 4 weeks (unknown frequency/week), as an outpatient. The PR-2 associated with the request

lists subjective complaints of neck pain with radicular symptoms to the left arm. There are no subjective complaints associated with the shoulder. The patient does have a history of tendinitis in the right shoulder, but it is unclear from the PR-2 what the physician is hoping to accomplish with chiropractic treatment. In addition, there is no frequency of treatment given in the RFA. Unspecified request for chiropractic treatment is not medically necessary.