

Case Number:	CM14-0040385		
Date Assigned:	06/27/2014	Date of Injury:	05/26/2009
Decision Date:	01/02/2015	UR Denial Date:	03/04/2014
Priority:	Standard	Application Received:	04/07/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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:

The patient is a 49 year old with an injury date on 5/26/09. Patient complains of improved right wrist pain rated 10/10 and aggravated by movement and touching volar surgical area, and back pain rated 9/10 with no leg pain, no numbness/tingling/weakness/incontinence per 1/24/14 report. Patient has been off work for over one year per 1/24/14 report. Based on the 1/24/14 progress report provided by the treating physician, the diagnoses are: 1. Complex Regional Pain Syndrome type 1 - improving 2. History of Carpal Tunnel Surgery 3. Right Medial Epicondylitis 4. Arthropathy of Lumbar Facet - no change 5. Degeneration of Lumbar Intervertebral Disc - no change Exam on 1/24/14 showed "right wrist has decreased range of motion. L-spine has decreased range of motion." Patient's treatment history includes work modifications, occupational therapy for right hand, chiropractic treatment, and medication (Flexeril, Nortriptyline, Lidoderm patches). The treating physician is requesting additional chiropractic treatment two times a week for three weeks, and occupational therapy two times a week for four weeks. The Utilization Review determination being challenged is dated 3/4/14. The requesting physician provided treatment reports from 9/13/13 to 2/10/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Chiropractic Treatment Two Times A Week For Three Weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Treatments. Manual therapy & manipulation Page(s): 58,59.

Decision rationale: This patient presents with back pain, and right wrist pain. The provider has asked for Additional Chiropractic Treatment two times a week for three weeks on 1/24/14. Patient states chiropractic treatment provides "some help" per 12/27/13 report. The utilization review letter dated 3/4/14 states patient had 26 chiropractic sessions. Patient has not been working for over one year per 1/24/14 report. MTUS guidelines allow up to 18 sessions of treatments following initial trial of 3-6 if functional improvements can be documented. MTUS guidelines allow 1-2 sessions of chiropractic treatment every 4 months if the patient is working. In this case, the patient has chronic pain condition, and 26 sessions of prior chiropractic treatment were beneficial. The patient is still not working at this time. For additional treatments, functional improvement as defined by labor code 9792.20(e) as significant change in ADL's, or change in work status, and reduced dependence on medical treatments must be documented. Given the lack of such documentation following recent Chiropractic Treatment, this request is not medically necessary.

Occupational Therapy Two Times A Week For Four Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98,99.

Decision rationale: This patient presents with back pain and right wrist pain. The provider has asked for Occupational Therapy two times a week for four weeks on 1/24/14. The patient "feels better" after occupational therapy per 12/27/13 report, and is currently taking OT per 1/24/14 report. The utilization review letter dated 3/4/14 states patient has completed 20 sessions of occupational therapy. MTUS guidelines allows for 8-10 sessions of physical therapy for various myalgias and neuralgias. In this case, the patient has a chronic pain condition, and a short course of treatment may be reasonable for a flare-up, declined function or new injury. However, the provider does not indicate any rationale or goals for the requested 8 sessions of therapy. Although the patient has responded positively to therapy treatments, there is no documentation of functional improvement as defined by labor code 9792.20(e) as significant change in ADL's, or change in work status, and reduced dependence on medical treatments. Furthermore, the requested 8 sessions exceed what is allowed by MTUS for this type of condition considering that the patient has had 20 sessions already. Therefore, this request is not medically necessary.