

Case Number:	CM15-0208491		
Date Assigned:	10/27/2015	Date of Injury:	07/07/2015
Decision Date:	12/09/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	10/22/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 38 year old female, who sustained an industrial injury on 07-07-2015. A review of the medical records indicates that the worker is undergoing treatment for left elbow myoligamentous injury, left ulnar nerve entrapment, left wrist sprain and strain and rule out left carpal tunnel syndrome. X-rays and nerve conduction studies of the left arm and wrist were noted to be negative. Subjective complaints on 07-23-2015 were noted to be pain that was rated as a 6 out of 10 but the location of pain was not documented. Objective findings were within normal limits. The treatment plan included a new pain medication. Subjective complaints (08-27-2015) included pain and tingling in the left fingers, wrist, forearm and elbow. Objective findings (08-27-2015) included tenderness of the left wrist, tenderness to palpation of the medial and lateral epicondyle, increased tingling to the medial arm with compressing cubital tunnel, decreased range of motion of the left wrist and positive median nerve compression test on the left. The treatment plan included continued physical therapy. Objective findings on 09-18-2015 revealed pain in the left wrist with grip testing, +3 tenderness to palpation of the medial left elbow, decreased and painful range of motion of the left elbow and wrist, +3 tenderness to palpation of the left volar wrist, radiating pain with Tinel's and numbness with carpal compression. The treatment plan included chiropractic treatment, physiotherapy, kinetic activities and referrals for functional capacity evaluation and hand specialist. No rationale was provided for these requests. There is no documentation of prior chiropractic therapy visits. Treatment has included pain medication, physical therapy, application of heat and ice and splinting. A utilization review dated 09-24-2015 modified a request for chiro x 18 to certification of chiro x 6 and non-certified a request for FCE referral.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiro x 18: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Forearm, Wrist & Hand (Acute & Chronic): Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: Per the MTUS Guidelines, chiropractic care consisting of manual therapy and manipulation for the low back is recommended for chronic pain if caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. A therapeutic trial of 6 visits over 2 weeks is recommended. If there is evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks is recommended. Elective or maintenance care is not recommended. Recurrences or flare-ups should be evaluated for treatment success, and if return to work is achieved, 1-2 visits every 4-6 months is reasonable. In this case, the request for 18 initial chiropractic visits exceeds the recommendations of the guidelines. A trial of 6 visits over 2 weeks is recommended initially to establish efficacy of the treatment. The request for Chiro x 18 is determined to not be medically necessary.

Functional Capacity Evaluation (FCE): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Work conditioning, work hardening. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Guidelines for Performing an FCE.

Decision rationale: The ODG provides criteria for when a functional capacity evaluation may be utilized. These criteria include repeated difficulty with returning to work, or when the injured worker is at or near reaching maximum medical improvement. Neither of these criteria are met for the injured worker to justify a functional capacity evaluation. Although there are other criteria that may warrant the use of a functional capacity evaluation, the injured worker's diagnoses and status do not apply to these criteria. The request for Functional Capacity Evaluation (FCE) is determined to not be medically necessary.

