

Case Number:	CM15-0032827		
Date Assigned:	02/26/2015	Date of Injury:	12/16/2011
Decision Date:	04/06/2015	UR Denial Date:	01/22/2015
Priority:	Standard	Application Received:	02/23/2015

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: Arizona, California

Certification(s)/Specialty: Family Practice

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 49 year old female sustained an industrial injury to the right shoulder, neck and right upper extremity on 9/1/11. The injured worker subsequently developed left shoulder pain with numbness and tingling of the left hand due to overcompensation. In a PR-2 dated 1/8/15, the injured worker complained of increasing bilateral shoulder and neck pain with tingling of the left ring and little fingers. Physical exam was remarkable for left wrist with full range of motion, negative Tinel, Phalen and Finkelstein tests and no tenderness to palpation, bilateral shoulders with full range of motion, pain upon abduction and tenderness to palpation to the anterior shoulder, 5/5 bilateral upper extremity strength, decreased sensation along the left ring and little fingers and cervical spine with full range of motion with slight tenderness to bilateral cervical spine paraspinal musculature without muscle spasms. Current diagnoses included left hand and wrist paresthesias, right wrist tenosynovitis, right elbow lateral epicondylitis, bilateral shoulder strain and cervical strain. The treatment plan included left upper extremity electromyography/ nerve conduction velocity test, chiropractic therapy once a week for six weeks and medications (Lodine 400 mg twice a day). On 1/22/15, Utilization Review noncertified a request for chiropractic x 6 and certified a request for EMG/NCS left upper extremity citing CA MTUS Chronic Pain Medical Treatment Guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic x 6: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58.

Decision rationale: According to the MTUS guidelines, Chiropractic therapy is considered manual therapy. It is recommended for chronic musculoskeletal pain. For Low back pain, therapeutic care is for 6 visits over 2 weeks with functional improvement up to a maximum of 18 visits over 8 weeks. The claimant had persistent symptoms in the neck and shoulders despite other conservative measures. As a result 6 sessions of chiropractor therapy is appropriate and medically necessary.

EMG/NCS left upper extremity: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

Decision rationale: According to the guidelines, an NCV/EMG is not recommended for diagnostic evaluation of nerve entrapment or screening in those without symptoms. An NCV is recommended for ulner nerve impingement after failure of conservative treatment. In this case, the claimant has left hand symptoms. The claimant was previously stationary and had undergone conservative treatment. Based on the guidelines and symptoms, the request is appropriate and medically necessary.