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| Case Number: | CM15-0061772 | | |
| Date Assigned: | 04/07/2015 | Date of Injury: | 11/12/2013 |
| Decision Date: | 05/07/2015 | UR Denial Date: | 03/09/2015 |
| Priority: | Standard | Application Received: | 04/01/2015 |

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, Minnesota

Certification(s)/Specialty: Chiropractor

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 48-year-old female, with a reported date of injury of 11/12/2013. The diagnoses include left shoulder calcific tendinitis, left shoulder tenosynovitis, left wrist sprain/strain, and left hand joint pain. Treatments to date have included chiropractic therapy, oral medications, an MRI of the left shoulder, an MRI of the left elbow, an MRI of the left wrist, and topical medications. The progress report dated 02/09/2015 indicates that the injured worker complained of constant, severe, sharp left shoulder pain which radiated to the left hand and fingers with numbness and tingling; left wrist pain with numbness, tingling, and weakness; and left hand pain with numbness, tingling, and weakness. The objective findings include decreased left shoulder range of motion, decreased left wrist range of motion, tenderness to palpation of the dorsal wrist, and decreased left hand range of motion. The treating physician requested six additional chiropractic therapy sessions for the left upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional chiropractic therapy x12 left upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): Manual therapy & Manipulation/Physical Medicine Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26 Page(s): 58&59.

Decision rationale: According to the MTUS Chronic Pain Guidelines above, manipulation of the upper extremities is not recommended to include Carpal tunnel syndrome, forearm, wrist, and hand. The doctor requested chiropractic therapy x12 left upper extremity. The above request is not according to the above guidelines and therefore the treatment is not medically necessary. Also 12 treatments would not have been according to the above guidelines for approved areas of injury.