

Case Number:	CM14-0146554		
Date Assigned:	09/12/2014	Date of Injury:	04/26/2013
Decision Date:	10/14/2014	UR Denial Date:	08/21/2014
Priority:	Standard	Application Received:	09/09/2014

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 a Licensed Chiropractor 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 reported to be a 57 year old female patient with a reported date of injury of 4/26/2013. Injured was seen by [REDACTED] on 2/16/14 for reported frequent moderated pain in the bilateral hands, left greater than right with numbness/tingling left greater than right; weakness reported bilaterally. Clinical evidence of Carpal Tinel tenderness reported with positive Tinel's present ; 10% worse with neck, left shoulder pain and bilateral wrist pain. Cervical ROM restricted, Jamar 20/22 right and 18/18 left' placed on TTD for 45 days. Reexamination by [REDACTED]: 6/7/14: no recommendation for further passive care only decompressive surgery. [REDACTED] followed this report with subsequent treatment requests for Chiropractor, Physical Therapy and Acupuncture on 7/10 and 8/7/14. Physical Therapy, Acupuncture and Chiropractic care requested for concurrent treatment were subsequently denied on/about 8/21/14. Care to the left shoulder was denied on 8/21/14 based on no clinical evidence of any left shoulder deficits necessitating Chiropractic care. EBM Guidelines does not support manipulation of the foreman, wrist or hand; frozen shoulder only.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic care, two sessions per week for four weeks, in treatment of the left shoulder, bilateral wrists and cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 173-174, 203-205, Chronic

Pain Treatment Guidelines Manual Therapy & Manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 74, 173-1.

Decision rationale: MTUS Chronic Treatment Guidelines support care with evidence of functional improvement: "Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit. In this case, there were no reported shoulder deficits outlined in the most recent reports from [REDACTED] that would support manipulation aside from frozen shoulder approved by CAMTUS Guidelines. The same Guidelines do not support manipulation of the shoulder absent deficits that would clearly respond to manual therapy; none were provided. Therefore, the request for chiropractic care, two sessions per week for four weeks, in treatment of the left shoulder, bilateral wrists and cervical spine is not medically necessary and appropriate.