

Case Number:	CM15-0120349		
Date Assigned:	06/30/2015	Date of Injury:	08/14/2013
Decision Date:	07/29/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	06/22/2015

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: Physical Medicine & Rehabilitation, Pain Management

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 34 year old male, who sustained an industrial injury on 08/14/2013. He has reported injury to the right hand/wrist. The diagnoses have included right hand severe laceration/RSD (Reflex Sympathetic Dystrophy Syndrome); status post-surgery right hand wrist laceration and crush injury; right wrist sprain/strain; right hand neuralgia; thoracic spine strain; right shoulder impingement; and insomnia. Treatment to date has included medications, diagnostics, acupuncture, chiropractic therapy, physical therapy, and surgical intervention. Medications have included Hydrocodone, Pantoprazole, and topical compounded creams. A progress report from the treating physician, dated 03/02/2015, documented an evaluation with the injured worker. Currently, the injured worker complains of constant, moderate right hand/wrist pain described as pulsating, burning, and numbness, increased by daily activities; constant, moderate right arm pain described as numbness, increased by lifting; and anxiety, sleeplessness, fatigue, and depression. Objective findings included tenderness on palpation of the right hand/wrist with limited, painful range of motion and positive orthopedic evaluation of the right upper extremity; decreased sensation at C5-C8 on the right; five-inch post-surgical scar; hand grip is 2+/5; unable to make a fist; Jamar testing is zero; right wrist with +4 tenderness to light touch palpation; and right shoulder with decreased range of motion. The treatment plan has included the request for chiropractic manipulation and therapy to the right wrist/hand 2x6; and ESWT (extracorporeal shockwave therapy) to the right hand/wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic manipulation & therapy to the right wrist/hand 2X6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manipulation Page(s): 58-60.

Decision rationale: Regarding the request for chiropractic care, the Chronic Pain Medical Treatment Guidelines state on pages 58-60 the following regarding manual therapy & manipulation: 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 of Manual Medicine 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. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care: Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care: Not medically necessary. Recurrences/flare-ups: Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. In the case of this injured worker, the request is directed to a body region (wrist/hand) that is specifically not recommended for manipulation per CPMTG. Given this, the request is not medically necessary.

ESWT to the right hand/wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow Chapter: Extra-corporal Shockwave Therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Policy of a National Insurer: Anthem Medical Policy # SURG.00045 Extra-corporeal Shock Wave Therapy for Orthopedic Conditions.

Decision rationale: Regarding the request for ECSWT (Extra-corporeal shock wave therapy) for the wrist, California MTUS does not address the issue. ODG does not address the issue for the wrists. Anthem medical policy notes that ESWT for the treatment of musculoskeletal conditions is considered investigational and not medically necessary. In light of the above issues, the currently requested ECSWT (Extra-corporeal shock wave therapy) for the wrist is not medically necessary.