

Case Number:	CM15-0077770		
Date Assigned:	04/29/2015	Date of Injury:	09/30/2012
Decision Date:	07/08/2015	UR Denial Date:	04/03/2015
Priority:	Standard	Application Received:	04/23/2015

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: New York
Certification(s)/Specialty: Emergency 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 41-year-old female who sustained an industrial injury on 9/30/12. The mechanism was reported to be cumulative trauma. The injured worker was diagnosed as having left shoulder, left wrist, and bilateral wrists and hand strains/sprains. Physical examination, previous imaging and treatments were not noted in the provided documentation. Previous diagnostic studies included radiographic studies. The plan of care was for chiropractic treatments and diagnostics.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-Ray Left Hand: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand.

Decision rationale: The ODG reference cited above recommends radiographs of the hand or wrist in cases of acute fractures or for "chronic wrist pain, first study obtained in patient with chronic wrist pain with or without prior injury, no specific area of pain specified. The injuries were not acute and not a result of direct trauma. There are no physical exam findings in the submitted documentation to indicate the specific area of pain. The request is for imaging of multiple areas of the bilateral upper extremities. It is unclear from the submitted records if the IW previously had imaging. Without the supporting documentation, the request for left hand x-ray is not medically necessary.

X-Ray Right Wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist and hand.

Decision rationale: The ODG reference cited above recommends radiographs of the hand or wrist in cases of acute fractures or for "chronic wrist pain, first study obtained in patient with chronic wrist pain with or without prior injury, no specific area of pain specified. The injuries were not acute and not a result of direct trauma. There are no physical exam findings in the submitted documentation to indicate the specific area of pain. The request is for imaging of multiple areas of the bilateral upper extremities. It is unclear from the submitted records if the Injured Worker previously had imaging. Without the supporting documentation, the request for right wrist x-ray is not medically necessary.

X-Ray Right Hand: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand.

Decision rationale: The ODG reference cited above recommends radiographs of the hand or wrist in cases of acute fractures or for "chronic wrist pain, first study obtained in patient with chronic wrist pain with or without prior injury, no specific area of pain specified. The injuries were not acute and not a result of direct trauma. There are no physical exam findings in the submitted documentation to indicate the specific area of pain. The request is for imaging of multiple areas of the bilateral upper extremities. It is unclear from the submitted records if the Injured Worker previously had imaging. Without the supporting documentation, the request for right hand x-ray is not medically necessary.

X-Ray Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder.

Decision rationale: CA MTUS is silent on this topic. According to the above-cited recommendation, radiographs of the shoulder are indicated only for acute, traumatic injuries. The submitted documentation does not support this was an acute injury nor what is a traumatic injury. Physical examination is not provided in the records for review. Without this documentation, the request for left shoulder x-ray is not medically necessary.

X-Ray Left Wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) .

Decision rationale: The ODG reference cited above recommends radiographs of the hand or wrist in cases of acute fractures or for "chronic wrist pain, first study obtained in patient with chronic wrist pain with or without prior injury, no specific area of pain specified. The injuries were not acute and not a result of direct trauma. There are no physical exam findings in the submitted documentation to indication the specific area of pain. The request is for imaging of multiple areas of the bilateral upper extremities. It is unclear from the submitted records if the IW previously had imaging. Without the supporting documentation, the request for left wrist x-ray is not medically necessary.

Chiropractic Treatment Physiotherapy 3 Times A Week for 6 Weeks (Left Shoulder, Left Hand and Wrist, Right Hand and Wrist): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: CA MTUS chronic pain guidelines for manual therapy and manipulation are used in support of this decision. It is assumed this request is for first time chiropractor evaluation and treatment. Documentation does not support the IW has previously undergone such treatments. According to referenced guidelines, manual therapies are recommended for musculoskeletal conditions. Nonetheless, a trial of 6 visits over 2 weeks with evidence of functional improvements. The request for 18 visits exceeds this recommendation. The request for 3 x 6-chiropractic treatment is not medically necessary.

ROM and JAMAR (Multiple Body Parts): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist and hand - exercises.

Decision rationale: Ca MTUS is silent. According to ODG reference cited, exercises are recommended for "specific hand and wrist exercises for range of motion and strengthening." These exercises are part of physical therapy assessment and plan of care. There is no indication from the submitted records that the IW has had a physical therapy assessment or any treatments. The request does not indicate specifically what body parts are being tested or who would be completing this evaluation. There is no request for physical therapy evaluation. Without the details of this request, specifically the body parts to be tested and the consultant for the procedure, the request for ROM and JAMAR testing is not medically necessary.