

Case Number:	CM13-0071943		
Date Assigned:	04/04/2014	Date of Injury:	10/17/2013
Decision Date:	05/09/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	12/30/2013

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 Board Certified in Internal Medicine & Emergency Medicine, and is licensed to practice in Florida. 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:

This patient is a 51 year-old with a date of injury of 10/17/13. Her original evaluation on 10/17/13 noted pain in the wrist due to repetitive activities and right knee pain. The mechanism for the knee pain was not described. Diagnoses included left carpal tunnel syndrome and sprain/strain of the right knee. A comprehensive progress report dated 11/25/13, identified subjective complaints of left hand numbness and tingling with weakness. Objective findings included a positive Phalen's test and thenar atrophy on the left. Exam of the neck, shoulders, and elbows was normal. Diagnoses included moderate to severe left carpal tunnel syndrome. No electrodiagnostic studies had yet been done. Treatment has included at least 5 PT sessions from 10/22/13 to 11/05/13. The evaluation stated that she was taking no medications. A brief progress report associated with the request for services on 12/04/13 was handwritten and difficult to read. It identified what appeared to be neck & knee pain. A Utilization Review determination was rendered on 12/27/13 recommending non-certification of "acupuncture, 1 time a week for 4 weeks; chiropractic therapy, 2 times a week for 4 weeks; urinalysis; interferential unit; motorized cold therapy with monthly supplies; and assay strap".

IMR ISSUES, DECISIONS AND RATIONALES

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

ACUPUNCTURE, 1 TIME A WEEK FOR 4 WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm,

Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 14 Ankle and Foot Complaints, Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Pain, Suffering, and the Restoration of Function..

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) states that acupuncture is used as an option when pain medication is reduced or not tolerated. It further states that acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range-of-motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The frequency and duration of acupuncture is listed as: - Time to produce functional improvement: 3 to 6 treatments. - Frequency: 1 to 3 times per week. - Optimum duration: 1 to 2 months. It is noted that acupuncture treatments may be extended if functional improvement is documented. In this case, there is no documentation of the use of medication or intolerance to medication. Therefore, there is no documented medical necessity for acupuncture as requested.

CHIROPRACTIC THERAPY, 2 TIMES A WEEK FOR 4 WEEKS: 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 Manual Therapy & Manipulation Page(s): 58-60.

Decision rationale: The California Chronic Pain MTUS Guidelines recommend manual therapy for chronic pain if caused by musculoskeletal conditions. For the low back, they recommend a trial of 6 visits over 2 weeks. If there is objective evidence of functional improvement, a total of up to 18 visits over 6-8 weeks are recommended. Manual manipulation is not recommended for peripheral joints; specifically the ankle & foot, carpal tunnel, forearm, wrist & hand, and knee. In this case, the site for chiropractic treatments is not defined. However, the records focus on the carpal tunnel syndrome. Chiropractic is not recommended for that syndrome. Therefore, there is no documented medical necessity for the requested chiropractic therapy.

URINALYSIS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 70. Decision based on Non-MTUS Citation Urinalysis in the Diagnosis of Kidney Disease.

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) does not address a diagnostic urinalysis specifically. Likewise, the request was not specified as a urine drug screen.

Authoritative sources such as UpToDate note that a urinalysis plays a central role in evaluation of acute and chronic kidney disease as well as diabetes mellitus. In this case, there is no documentation of the presence of acute or chronic kidney disease. Likewise, none of the prescribed oral therapy requires periodic monitoring with a urinalysis. Therefore, there is no documented medical necessity in the record for a urinalysis.

INTERFERENTIAL UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulator (ICS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181, Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS), Transcutaneous Electrotherapy Page(s): 54, 114-120.

Decision rationale: Interferential Current Stimulation (IF) therapy is a type of transcutaneous electrotherapy, similar to TENS, but with different electrical specifications. The California Medical Treatment Utilization Schedule (MTUS) states that TENS is not recommended for the neck & upper back. For other conditions, a one month trial of transcutaneous therapy is considered appropriate if used as an adjunct to an evidence-based program of functional restoration. The recommended types of pain include: - Neuropathic pain - CRPS I and II - Phantom limb pain - Spasticity - Multiple sclerosis For chronic intractable pain from these conditions, the following criteria must be met: - Documentation of pain for at least three months duration. - Evidence that other appropriate pain modalities have been tried (including medication) and failed. - A one-month trial period of the TENS unit should be documented with documentation of how often it was used, as well as the outcomes in terms of pain relief and function. - Other ongoing pain treatment should also be documented during the trial period including medication usage. - A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. Specifically, Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. While studies are mixed as its effectiveness, the Guidelines note that if used, the following patient selection criteria should be used: - Pain is ineffectively controlled due to diminished effectiveness of medications; OR - Pain is ineffectively controlled with medications due to side effects; - History of substance abuse; OR - Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; OR - Unresponsive to conservative measures. If these criteria are met, then a one-month trial may be appropriate. A jacket should not be authorized for a one-month trial. In this case, the ICS unit is being requested for a type of pain not indicated for treatment. Also, the multiple criteria noted above (documentation of duration of pain, trial plan, and goal plan) have not been met. Last, a one-month trial should be attempted. Therefore, there is no documented medical necessity for an Interferential Current Stimulation Unit (ICS) unit.

MOTORIZED COLD THERAPY WITH MONTHLY SUPPLIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214. Decision based on Non-MTUS Citation ODG - Cryotherapy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous-flow Cryotherapy.

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) states that at-home applications of heat or cold packs to aid exercises are optional. The Official Disability Guidelines (ODG) state that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use may be up to 7 days, including home use. The Guidelines recommend continuous-flow cryotherapy postoperatively for up to 7 days. In this case, the claimant is not postoperative. Therefore, the record does not document the medical necessity for a cold therapy unit.

ASSAY STRAP: Upheld

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: The Medical Treatment Utilization Schedule (MTUS) states that prolonged orthotic modalities are only optional. The record does not document the request, nature, or intended purpose of an assay strap. Therefore, there is no documentation for the medical necessity of an assay strap.