

<b>Case Number:</b>	CM14-0000987		
<b>Date Assigned:</b>	01/22/2014	<b>Date of Injury:</b>	08/08/2012
<b>Decision Date:</b>	06/13/2014	<b>UR Denial Date:</b>	12/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/03/2014

### 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 Board Certified in Preventative Medicine and Occupational Medicine and is licensed to practice in Texas. 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 injured worker is a 51 year old female whose date of injury is 08/08/2012. The mechanism of injury is described as repetitive typing. EMG/NCV dated 02/28/13 revealed evidence of mild, right greater than left carpal tunnel syndrome and no evidence of cervical radiculopathy. Per agreed medical examination dated 03/06/13, the injured worker is capable of performing her regular duties. Follow up note dated 11/20/13 indicates that the injured worker is currently in physiotherapy 2-3 times a week. Diagnoses are listed as cervical disc bulge with radiculitis, bilateral carpal tunnel syndrome, lumbar disc bulge with radiculitis, shoulder tendonitis bilaterally, and thoracic outlet syndrome. Evaluation dated 12/30/13 indicates that cervical range of motion is flexion 10, extension 10, bilateral lateral flexion 15, and bilateral rotation 20 degrees. Lumbar range of motion is flexion 60, extension 20, bilateral lateral flexion 30, and bilateral rotation 20 degrees.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS UNIT FOR USE AT HOME:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation Page(s): 114-116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-117.

**Decision rationale:** Based on the clinical information provided, the request for TENS unit for use at home is not recommended as medically necessary. The submitted records fail to establish that the injured worker has undergone a successful trial of TENS as required by CA MTUS guidelines to establish efficacy of treatment and support home use. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals were provided.

**FUNCTIONAL CAPACITY EVALUATION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition: Independent Medical Examinations and Consultations Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter, Functional capacity evaluation.

**Decision rationale:** Based on the clinical information provided, the request for functional capacity evaluation is not recommended as medically necessary. Per agreed medical examination dated 03/06/13, the injured worker is capable of performing her regular duties. The submitted records fail to establish that the injured worker is close or at maximum medical improvement or that there has been a history of prior unsuccessful return to work attempts, as required by the Official Disability Guidelines. There is no current, detailed physical examination submitted for review and there is no clear rationale provided to support a functional capacity evaluation at this time.

**PHYSIOTHERAPY (2) TIMES A WEEK FOR (3) WEEKS FOR THE LUMBAR AND CERVICAL SPINE, BILATERAL HANDS/WRISTS:** Upheld

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

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

**Decision rationale:** Based on the clinical information provided, the request for physiotherapy 2 times a week for 3 weeks for the lumbar and cervical spine, bilateral hands/wrists is not recommended as medically necessary. The injured worker has undergone prior physiotherapy. The injured worker's compliance with a home exercise program is not documented. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals were provided. CA MTUS guidelines would support 1-2 visits every 4-6 months for recurrence/flare-up and note that elective/maintenance care is not medically necessary.

**CERVICAL SPINE EPIDURAL STEROID INJECTION:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS Page(s): 46.

**Decision rationale:** Based on the clinical information provided, the request for cervical spine epidural steroid injection is not recommended as medically necessary. The request is nonspecific and does not indicate the level/laterality to be injected. There is no current, detailed physical examination submitted for review to establish the presence of cervical radiculopathy, and the submitted EMG/NCV does not reveal any evidence of cervical radiculopathy. CA MTUS guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results.