

Case Number:	CM14-0002242		
Date Assigned:	01/24/2014	Date of Injury:	06/19/2012
Decision Date:	06/26/2014	UR Denial Date:	01/03/2014
Priority:	Standard	Application Received:	01/07/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 35-year-old female with a reported date of an injury on 06/19/2012. The injury reportedly occurred while the worker was helping a wheelchair-bound client into the handicap bus. The injured worker complained of low back pain and left wrist pain. According to the clinical documentation provided, the injured worker underwent a lumbar MRI on 11/06/2012, which revealed L4-5, 3 to 4mm bulge. On 10/25/2013, the injured worker underwent a left wrist MRI which revealed subchondral cyst formation. In addition, the injured worker underwent electro-diagnostic studies (EMG and NCV) on 11/14/2013 which revealed no acute or chronic degenerative potentials. In addition, normal NCV studies of the upper extremities did not reveal any electro physical evidence of peripheral nerve entrapment. According to the documentation provided, the injured worker has utilized chiropractic treatment since 2012. The injured worker reported her low back pain was 5/10 and wrist pain was 4/10. According to the clinical note dated 01/08/2014, the injured worker's range of motion was represented as dorsiflexion 60 degrees bilaterally, palmar flexion 60 degrees bilaterally, ulnar and radial deviation at 30 degrees bilaterally. The injured worker's lumbar spine range of motion was represented as flexion to 50 degrees, extension to 10 degrees, right and left bends to 20 degrees. In addition, all upper and lower extremity muscle strength was rated at 5/5. The injured worker's diagnoses included left wrist sprain/strain, subchondral cyst, and lumbosacral spine strain/sprain, lumbar spine disc bulge at L3-4, L4-5, and L5-S1 without radiculopathy. The Request for Authorization of a TENS unit, hot and cold pack/wrap, thermal combo unit, retrospective request (DOS: 10/07/2013) for a urine drug screen, retrospective request (DOS: 11/04/2013) for a urine drug screen, continued chiropractic treatment (1x6) for the left wrist and lower back, continued acupuncture treatment (1x6) for the left wrist and lower back, MRI of the lumbar spine, retrospective request (DOS: 10/25/2013) for an MRI of the left wrist, retrospective

request (DOS: 11/14/2013) for EMG of the bilateral upper extremities, retrospective request (DOS: 11/14/2013) for an NCV in the bilateral upper extremities, EMG of the bilateral lower extremities, NCV of the bilateral lower extremities, orthopedic consultation and retrospective request (DOS: 11/04/2013) for Exoten-C pain relief lotion was submitted on 01/07/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116.

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

Decision rationale: According to the California MTUS Guidelines, a TENS unit is not recommended as a primary treatment modality, but a 1 month home-based TENS trial may be considered as a noninvasive conservative option, if used in an addition to physical therapy. The use of a TENS unit would include documentation of pain relief. According to the California MTUS Guidelines in the use of a TENS unit, the short and long term goals of treatment with a TENS unit should be submitted. The documentation provided for review does not specify region of the body the TENS unit was requested for. The documentation was unclear as to whether or not the injured worker was involved in an ongoing rehab program. In addition, there is a lack of documentation provided related to the short and long term goals in utilizing the TENS unit for the treatment of the injured worker. The request as submitted failed to indicate whether the request was for a rental or purchase. Therefore, the request for a TENS unit is not medically necessary.

HOT AND COLD PACK/WRAP: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Cold/Heat Packs.

Decision rationale: The CA MTUS/ACOEM guidelines recommend local application of cold in the first few days of acute complaint. Thereafter, the guidelines recommend application of heat or cold. The Official Disability Guidelines recommend hot/cold pack wrap therapy as an option for acute pain. The request does not specify if this is for purchase or rental of a hot/cold pack wrap. In addition, the documentation does not specify a region of the body in the use of the hot/cold pack. The rationale for the request of hot/cold pack wrap is unclear, as the injured worker was not in the acute phase of injury. Therefore, the request for hot and cold pack/wrap is not medically necessary.

THERMAL COMBO UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, 308.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-289. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Heat Therapy.

Decision rationale: According to the CA MTUS/ACOEM guidelines, relieving discomfort can be accomplished with the use of thermal modalities such as ice and/or heat. The Official Disability Guidelines recommend thermal combo unit as an option. Studies have shown continuous low level heat wrap therapy to be effective for treating low back pain. Combining continuous low level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared with intervention alone. The clinical documentation provided for review does not specify a region of the body for the use of the thermal combo unit. Rationale for the request is not clear in the documentation provided for review, as the injured worker was not in the acute phase of injury. Therefore, the request for thermal combo wrap is not medically necessary.

RETROSPECTIVE REQUEST (DOS: 10/7/13) FOR A URINE DRUG SCREEN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77-80, 94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend the use of a urine drug screen to assist for the presence of illegal drugs or noncompliance with prescribed medication. Information provided for review did not include a list of the injured worker's medication. There was a lack of documentation regarding physician concern of illegal drug use or medication noncompliance. In addition, the rationale for a second urine drug screen was unclear. The prior screening was completed and documented as compliant with medication prescribed. The rationale for the urine drug screen was not provided within the documentation available for review. Therefore, the retrospective request for 10/07/2013 urine drug screen is not medically necessary.

RETROSPECTIVE REQUEST (DOS: 11/4/13) FOR A URINE DRUG SCREEN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77-80, 94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

Decision rationale: The California MTUS Guidelines recommend the use of a urine drug screen to assist for the presence of illegal drugs or noncompliance with prescribed medication. Information provided for review did not include a list of the injured worker's medication. There was a lack of documentation regarding physician concern of illegal drug use or medication noncompliance. In addition, the rationale for a second urine drug screen was unclear. The prior screening was completed and documented as compliant with medication prescribed. The rationale for the urine drug screen was not provided within the documentation available for review. Therefore, the retrospective request for 11/4/13 urine drug screen is not medically necessary.

CONTINUED CHIROPRACTIC TREATMENT (1X6) FOR THE LEFT WRIST AND LOWER BACK: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

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

Decision rationale: According to the California MTUS Guidelines, manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Effective manual medicine is the achievement of positive symptomatic or objective measurable gains and functional improvement that facilitates progression in the patient's therapeutic exercise programs and return to productive activities. According to the California MTUS Guidelines, manual therapy to the wrist is not recommended. Chiropractic treatment frequency and duration for low back conditions recommend an initial trial of 6 to 12 weeks over a 2 to 4 week period. According to the guidelines, at the end of the trial there should be a formal assessment of satisfactory clinical gains related to the chiropractic treatment. According to the documentation provided for review, the injured worker has undergone chiropractic treatments for an unspecified amount of visits. There is a lack of documentation related to increase in functional ability related to the chiropractic visits. The rationale for the continued chiropractic treatment is unclear. In addition, this California MTUS Guidelines do not recommend manual therapy to the wrist. As the injured worker has attended chiropractic treatment, the request for 6 additional treatments exceeds recommended guidelines. Therefore, the request for continued chiropractic treatment (1 x 6) for the left wrist and lower back is not medically necessary.

CONTINUED ACUPUNCTURE TREATMENT (1X6) FOR THE LEFT WRIST AND LOWER BACK: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to the Acupuncture Medical Treatment Guidelines, acupuncture is used as an option when pain medication is reduced or not tolerated, and it may be used in addition to physical rehabilitation and/or surgical intervention to hasten functional recovery. Time to produce functional improvement is 3 to 6 treatments. According to the clinical documentation provided for review, the injured worker has attended acupuncture treatments of undocumented duration. There was a lack of documentation provided related to the functional benefit of previous acupuncture. In addition, the request for an additional 6 acupuncture treatments exceeds the recommended guidelines. Therefore, the request for continued acupuncture treatment (1x6) for the left wrist and lower back is not medically necessary.

MRI OF THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Pain, MRIs (magnetic resonance imaging).

Decision rationale: The Official Disability Guidelines do not routinely recommend repeat MRI's. According to the guidelines repeat MRI's should be reserved for a significant change in symptoms and /or findings suggestive of significant pathology. The lumbar MRI dated 11/06/2012 revealed at L4-5 a 3 to 4mm bulge. The documentation provided for review did not provide object clinical findings of new or worsening neurological deficits that would indicate a need for a second MRI. In addition, there is no evidence that there were additional clinical findings or symptom complaints to warrant a repeat MRI. The rationale for the request was unclear. Therefore, the request for the MRI of the lumbar spine is not medically necessary.

RETROSPECTIVE REQUEST (DOS: 10/25/13) FOR AN MRI OF THE LEFT WRIST:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273.

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

Decision rationale: According to the ACOEM guidelines, most injured workers presenting with true hand and wrist problems, special studies are not needed until after a 4- to 6-week period of conservative care and observation. There is a lack of documentation provided for review related to the functional deficits in the injured worker's left wrist. There is a lack of documentation related to physical therapy and the benefit or lack of benefit related to the injured worker's pain or functional deficits in the left wrist. The rationale for the left wrist MRI is unclear. Therefore, the request for retrospective request (DOS: 10/25/13) for an MRI of the left wrist is not medically necessary.

RETROSPECTIVE REQUEST (DOS: 11/14/13) FOR EMG OF THE BILATERAL UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

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

Decision rationale: According to the CA MTUS/ACOEM Guidelines, for injured workers presenting with true hand and wrist problems, special studies are not needed until after a 4- to 6-week period of conservative care and observation. Most patients improve quickly, provided red flag conditions are ruled out. In cases of peripheral nerve impingement, if no improvement or worsening has occurred within four to six weeks, electrical studies may be indicated. According to the documentation provided for review, the documentation did not represent objective clinical findings of neurological deficits. In addition there was a lack of documentation related to physical therapy. Rationale for the EMG is unclear, therefore, the retrospective request for DOS 11/14/2013 for EMG of the bilateral upper extremities is not medically necessary.

RETROSPECTIVE REQUEST (DOS: 11/14/13) FOR NCV OF THE BILATERAL UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

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

Decision rationale: According to the ACOEM Guidelines, in the case of peripheral nerve impingement, if no improvement or worsening has occurred within four to six weeks, electrical studies may be indicated. Imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggest specific disorders. There was a lack of documentation related to physical therapy provided for review. According to the documentation provided for review, the documentation did not represent objective clinical findings of neurological deficits. In addition there was a lack of documentation related to physical therapy. Rationale for the NCV is unclear, therefore, the retrospective request for DOS 11/14/2013 for NCV of the bilateral upper extremities is not medically necessary.

EMG OF THE BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: According to the ACOEM Guidelines, for those patients presenting with true neck or upper back problems, special studies are not needed unless a 3 or 4 week period of conservative care and observation fails to improve symptoms. Criteria for ordering imaging studies would include emergence of a red flag, physiological evidence of tissue insult or neurological dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to invasive procedure. According to the documentation provided for review, the injured worker did not have objective clinical findings of neurological deficits. In addition there was a lack of documentation related to physical therapy. Rationale for the EMG is unclear; therefore, the retrospective request for EMG of the bilateral lower extremities is not medically necessary.

NCV OF THE BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Nerve Conduction Studies (NCS).

Decision rationale: The Official Disability Guidelines does not recommend nerve conduction studies. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. According to the documentation provided for review, the injured worker does not have neurological deficits. There was a lack of documentation related to physical therapy. Rationale for the NCV is unclear; therefore, the request for NCV of the bilateral lower extremities is not medically necessary.

ORTHOPEDIC CONSULTATION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, , 127

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

Decision rationale: The Official Disability Guidelines recommend office visits as determined to be medical necessary. Evaluation and management of outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker, and this should be encouraged. A determination of office visits is also based on what medications the injured worker is taking, since some medicines such as opioids or medicines such as certain antibiotics require close monitoring. As injured worker's conditions are extremely varied, sudden number of office visits per condition cannot be reasonably established. The request for orthopedic consultation is unclear. The clinical information provided for review did not provide objective findings of new or increased functional deficits. Therefore, the request for orthopedic consultation is not medically necessary.

**RETROSPECTIVE REQUEST (DOS: 11.4.13) FOR EXOTEN C PAIN RELIEF
LOTION: Upheld**

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105, 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals & Topical Analgesics Page(s): 105, 111-112.

Decision rationale: According to the California MTUS Guidelines, salicylate topicals are recommended. According to the guidelines, capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. According to the guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In addition, any compounded product that contains at least 1 drug that is not recommended is not recommended. According to the documentation provided for review, there is no documentation that the patient was intolerant to oral antidepressants or anticonvulsants. The clinical information provided for review lacked documentation regarding physical therapy or other therapies that have been utilized. The request does not specify a region of the body to be utilized. In addition, the injured worker did not have a diagnosis of neuropathy or objective clinical findings of neuropathy. Therefore, the retrospective request (DOS: 11.4.13) for Exoten-C pain relief lotion is not medically necessary.