Case Number:	CM14-0106655		
Date Assigned:	08/08/2014	**Date of Injury:**	04/09/2014
Decision Date:	09/24/2014	**UR Denial Date:**	06/23/2014
Priority:	Standard	**Application Received:**	07/09/2014

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 Occupational Medicine and is licensed to practice in California. 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:

There were 291 pages provided for review. The request for independent medical review was signed on July 2, 2014. There were multiple requests in this review. Per the records provided, the patient was described as a 20-year-old female worker who had a date of injury of April 9, 2014. It was reportedly a cumulative trauma injury. She allegedly sustained injuries to the low back, both hands and wrists while performing her usual customary duties as a laborer. She had symptoms due to the repetitive nature of the job duties she was required to perform on a daily basis. She was required to pack boxes with produce and then lifting and carrying the boxes outside, and stacking them. The symptoms on the day of the report were pain in the low back at eight out of 10 that travels to the legs. Is it is accompanied by tingling and numbness. Bilateral hand pain was six out of 10 accompanied by tingling and numbness. The thoracolumbar spine had tenderness, muscle spasm, and a positive sitting straight leg raise bilaterally. There was decreased range of motion with pain. Wrist examination showed pain and edema of both wrists, a positive Tinel's bilaterally, a positive Phalen's bilaterally, and decreased range of motion in both wrists, and pain. There was decreased grip strength of both hands. No grip strength numerical values were listed for comparison. The decreased sensation was mentioned, but no dermatome levels were noted. She was expected to return to modified work by March 6 with no lifting over 30 pounds. As of June 2, 2014, there was a dull lumbar pain radiating to the legs with numbness tingling and weakness. There was no quantification or numerical values listed in regards to the weakness. The previous reviewer noted that in regards to the chiropractic treatment, on top of the six already rendered, there was no evidence of significant objective progress or improved examination findings to support the necessary of the additional chiropractic treatment beyond the initial trial of six chiropractic visits. There were several concerns regarding the other care requests as well.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment 3x4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58 of 127.

Decision rationale: The MTUS stipulates that the intended goal of this form of care 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. These records fail to attest to 'progression of care' or 'functional improvement' under the MTUS.The guides further note that treatment beyond 4-6 visits should be documented with objective improvement in function. This patient, being injured in April, is now 5 months post injury again without objective improvement in function noted. Further, in Chapter 5 of ACOEM, it speaks to leading the patient to independence from the healthcare system, and self care. It notes that over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general. The patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization. With 18 automatic sessions per year, this key concept of MTUS ACOEM is not met. The request was appropriately non-certified.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

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

Decision rationale: Under MTUS/ACOEM, although there is subjective information presented in regarding increasing pain, there are little accompanying physical signs that would drive a necessity for advanced imaging of the lumbar spine. Even if the signs are of an equivocal nature, the MTUS note that electrodiagnostic confirmation generally comes first. They note 'Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study.' The guides warn that indiscriminate imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. I did not find electrodiagnostic studies. It can be said that ACOEM is intended

for more acute injuries; therefore other evidence-based guides were also examined. These criteria are also not met in this case; the request was appropriately non-certified under the MTUS and other evidence-based criteria.

MRI of the bilateral wrists: 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).

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

Decision rationale: Regarding MRI of the wrist, the ODG notes: Recommended as indicated: While criteria for which patients may benefit from the addition of MRI have not been established, in selected cases where there is a high clinical suspicion of a fracture despite normal radiographs, MRI may prove useful. (ACR, 2001) (Schmitt, 2003) (Valeri, 1999) (Duer, 2007). Magnetic resonance imaging has been advocated for patients with chronic wrist pain because it enables clinicians to perform a global examination of the osseous and soft tissue structures. It may be diagnostic in patients with triangular fibrocartilage (TFC) and intraosseous ligament tears, occult fractures, avascular neurosis, and miscellaneous other abnormalities. Indications for imaging -- Magnetic resonance imaging (MRI):- Chronic wrist pain, plain films normal, suspect soft tissue tumor- Chronic wrist pain, plain film normal or equivocal, suspect Kienbck's disease- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008)In this case, under chronic wrist pain indications, there is neither suspicion of occult fracture, Kienbock's disease, or significant change of symptoms suggestive of significant pathology. Further, the mechanism of injury simply would not lead to a fracture. This request was appropriately non-certified.

Heating pad: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

Decision rationale: This durable medical equipment item is a device to administer regulated heat. However, the MTUS/ACOEM guides note that 'during the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise. They are most effective when the patient uses them at home several times a day'. Elaborate equipment is simply not needed to administer heat modalities even a heating wrap; the guides note it is something a claimant can do at home with simple home hot and cold packs made at home, without the need for such equipment. As such, this DME would be superfluous and not necessary, and not in accordance with MTUS/ACOEM. The request was appropriately non-certified.

Unspecified belt: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

Decision rationale: The California MTUS, specifically Chapter 12 of ACOEM dealing with the low back, note on page 298: Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. However, it is not precisely clear what the provider was requesting with the term 'belt'. That alone makes this a non-certifiable request. Given the vagueness of the request, the services is not certifiable under MTUS.

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 Page(s): 116 of 127.

Decision rationale: The MTUS notes that TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below.- Neuropathic pain: Some evidence (Chong, 2003), including diabetic neuropathy (Spruce, 2002) and post-herpetic neuralgia. (Niv, 2005)- Phantom limb pain and CRPS II: Some evidence to support use. (Finsen, 1988) (Lundeberg, 1985)- Spasticity: TENS may be a supplement to medical treatment in the management of spasticity in spinal cord injury. (Aydin, 2005) - Multiple sclerosis (MS): While TENS does not appear to be effective in reducing spasticity in MS patients it may be useful in treating MS patients with pain and muscle spasm. (Miller, 2007)I did not find in these records that the claimant had these conditions. Also, an outright purchase is not supported, but a monitored one month trial, to insure there is objective, functional improvement. In the trial, there must be documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. There was no evidence of such in these records. The request was appropriately non-certified.

NCV of upper extremities: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 271.

Decision rationale: The MTUS ACOEM notes that electrodiagnostic studies may be used when the neurologic examination is unclear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. In this case, a prime symptoms described was wrist pain, which is an atypical finding for an entrapment neuropathy. The California MTUS-ACOEM guidelines, Chapter 11, Table 11 7a, page 271, Summary of Recommendations for Evaluating and Managing Forearm, Wrist, and Hand Complaints, were reviewed for this request. Per ACOEM guides on page 260: CTS does not produce hand or wrist pain. It most often causes digital numbing or tingling primarily in the thumb, index, and long finger or numbness in the wrist. Symptoms of pain, numbness, and tingling in the hands are common in the general population, but based on studies, only about one in five symptomatic subjects would be expected to have CTS based on clinical examination and electrophysiologic testing.The request was appropriately non-certified as the request was not congruent with the patient's pain complaints.

NCV of lower extremities: 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).

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

Decision rationale: The MTUS ACOEM notes that electrodiagnostic studies may be used when the neurologic examination is unclear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. In this case, there was not a neurologic exam of the lower extremities showing definitively equivocal signs that might warrant clarification with electrodiagnostic testing. Testing should not take the place of basic physician clinical neurologic examination. The request was appropriately non-certified.

Orthopedic evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, chapter 6, page 112.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ACOEM), 2nd Edition, (2004). Chapter 7, Page 127.

Decision rationale: ACOEM Guidelines, Chapter 7, Page 127, state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient. This request for the consult fails to specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues,

diagnosis, causal relationship, prognosis, temporary or permanent impairment, work capability, clinical management, and treatment options. The request is not medically necessary.