

<b>Case Number:</b>	CM14-0108236		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	05/14/2014
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	06/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/11/2014

### 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 California and Washington. 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 48-year-old male with a reported injury on 05/14/2013. The mechanism of injury was due to him performing his usual duties and customary work as a cook having sustained cumulative trauma and injury to his shoulders, wrists, and low back. The diagnoses included bilateral carpal tunnel syndrome, moderately severe right and mild to moderate on the left, right shoulder full thickness rotator cuff tear with impingement syndrome with AC arthropathy, left shoulder impingement and rotator cuff tendinopathy, and lumbar sprain/strain and degenerative disc disease. There are no previous treatments that were provided for review. Although, it was stated that the injured worker has not begun physical therapy yet. The injured worker had an examination evaluation on 06/04/2014 with complaints of continued bilateral shoulder, wrist, and low back pain. He rated his pain between 3/10 and 4/10. He complained that his pain increased with activity to his shoulders and his wrists. He did complain of numbness and tingling in the thumb, index finger, and middle finger. Upon examination with his low back pain, he also had numbness in the right leg to the top of his foot. The list of medications included omeprazole, pravastatin, and ibuprofen. The recommended plan of treatment is to request for authorization for physical therapy, to have the lumbar cold pack with a strap, bilateral carpal tunnel splints, bilateral carpal tunnel injections, and a left subacromial injection. The Request for Authorization was signed and dated for 06/05/2014. The rationale was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ossur lumbar Cold Pack with Strap:** 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), 2014 Shoulder and Low Back.

**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, cold/heat packs.

**Decision rationale:** The California MTUS and ACOEM Guidelines do not address this request. The Official Disability Guidelines recommend cold packs as an option for acute pain. Usually the applications of cold packs are for the first few days of acute complaints, and then thereafter, the application of heat packs or cold packs. Evidence for the application of cool treatment to low back pain is more limited than heat therapy with only 3 poor quality studies located that support its use. There is minimal evidence supporting the use of cold therapy. There is a lack of evidence to support the medical necessity of a lumbar cold pack with a strap. Therefore, the request for Ossur lumbar Cold Pack with Strap is not medically necessary.

**Bilateral Carpal Tunnel Splints:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265-266.

**Decision rationale:** The request for Bilateral Carpal Tunnel Splints is not medically necessary. The ACOEM Guidelines does show evidence that supports the efficacy of neutral wrist splints for the treatment of carpal tunnel syndrome. It suggests that splinting should be used at night and may be used during the day, depending upon activity. There is a lack of evidence that the splints are neutral wrist splints in the request, and also there is a lack of directions as far as the frequency and the duration that the splints are to be worn. There was mention that the injured worker already has used splints. There is no evidence to support the need for another one. The clinical information provided fails to meet the evidence based guidelines for the request. Therefore, the request for Bilateral Carpal Tunnel Splints is not medically necessary.

**Physical Therapy two times a week for six weeks for the Left Shoulder and Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Treatment Page(s): 130.

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

**Decision rationale:** The California MTUS Guidelines recommend based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. There is a lack of evidence of flexibility and strength, endurance and functional deficits. There was not an efficacy of the medications as far as pain; there are, however, range of motion deficits noted. The California MTUS Guidelines also state that patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There is lack of evidence that the injured worker was instructed to be on a home exercise program. Furthermore, the request asked for a total of 12 sessions; guidelines recommend up to 10 sessions. There is a lack of evidence to support the medical necessity of 12 sessions without further evaluation and assessment. Therefore, the request for physical therapy twice a week for six weeks for the left shoulder and lumbar spine is not medically necessary.