

<b>Case Number:</b>	CM14-0017954		
<b>Date Assigned:</b>	04/16/2014	<b>Date of Injury:</b>	02/26/2013
<b>Decision Date:</b>	06/02/2014	<b>UR Denial Date:</b>	02/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2014

### 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 and Rehabilitation 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:

The injured worker is a 45-year-old female who reported an injury on 02/26/2013. The mechanism of injury was not stated. The current diagnosis is chronic neck pain with disc protrusion. The latest Physician Progress Report submitted for this review is documented on 10/28/2013. The injured worker reported 6/10 pain in the right wrist. The injured worker also reported left elbow pain and left shoulder pain. Physical examination revealed diminished grip strength, sensory deficit on the left side at the C5 dermatome, limited cervical range of motion, spasm, positive Valsalva maneuver on the left, positive cervical distraction testing, positive Jackson compression testing, positive maximum cervical compression testing, and positive shoulder depression testing. The treatment recommendations at that time included CMT, US, EMS, traction, myofascial release/trigger point therapy, stretching and strengthening twice per week for 4 weeks as well as a wrist and elbow brace.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CMT, US, MES, TRACTION, MYOFASCIAL RELEASE/TRIGGER POINT THERAPY, STRETCHING/ RESISTIVE/STRENGTHENING - 2 TIMES A WEEK FOR 4 WEEKS:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy And Manipulation..

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

**Decision rationale:** California MTUS Guidelines state manual therapy and manipulation are recommended if caused by a musculoskeletal condition. Treatment for the forearm, wrist and hand is not recommended. Therefore, the current request cannot be determined as medically appropriate. There is no specific body part listed in the current request. Therefore, the request is not medically necessary.

**WRIST AND ELBOW BRACE:** 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): 265-266.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state when treating with a splint and carpal tunnel syndrome, scientific evidence supports the efficacy of neutral wrist splints. Splinting should be used at night and may be used during the day, depending upon activity. Any splinting or limitations placed on the hand, wrist and forearm should not interfere with total body activity. As per the documentation submitted, there is no evidence of carpal tunnel syndrome. There is no documentation of a significant musculoskeletal or neurological deficit with regard to the wrist and elbow. There was no evidence of instability upon physical examination. The medical necessity for the requested durable medical equipment has not been established. It is also noted that the injured worker was issued a wrist and elbow brace on 09/10/2013. The medical necessity for additional braces has not been established. As such, the request is not medically necessary.

**ORTHOPEDIC REFERRAL FOR EPIDURAL/CORTISONE INJECTIONS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Independent Medical Examinations And Consultations Regarding Referrals, Chapter 7.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry with treating a particular cause of delayed recovery or has difficulty obtaining information or an agreement to a treatment plan. There is no mention of an exhaustion of conservative treatment. There were no imaging studies provided for review to corroborate a diagnosis of radiculopathy prior to consideration for an epidural steroid injection. The medical necessity for the requested referral has not been established. As such, the request is not medically necessary.