MAXIMUS Federal Services

Case Number:	CM14-0150295		
Date Assigned:	09/18/2014	Date of Injury:	12/04/2010
Decision Date:	10/30/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/15/2014

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 48-year-old female who reported an injury on 10/04/2010 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to the right wrist and lumbar spine. The injured worker was evaluated on 08/11/2014. It is noted that the injured worker has had increased right wrist pain in the last 3 months and increased low back pain with loss of motion and decreased function. Physical findings included positive Finkelstein's, Tinel's, and Phalen's tests of the right wrist with slight swelling. Evaluation of the lumbar spine documented tenderness to palpation with decreased range of motion and a positive straight leg raising test for low back pain. The injured worker's diagnoses included lumbar sprain/strain, right lower extremity radiculitis, and right wrist tenosynovitis. The injured worker's treatment plan included chiropractic care and ergonomic evaluation of the patient's workstation, an OrthoStim 4 home unit, a back brace, and Anaprox. A Request for Authorization form was submitted on 08/11/2014 to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ergononomic Evaluation of workstation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 1 Prevention. Decision based on Non-MTUS Citation Official Disability Guidelines Forearm, Wrist and had Chapter- Ergonomic Interventions

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ACOEM), 2nd Edition, (2004) 1, page(s) 1-5 ODG) Carpal Tunnel Chapter, Ergonomic interventions

Decision rationale: The requested Ergononomic Evaluation of workstation is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does recommend work modifications to assist with symptom control. However, Official Disability Guidelines further recommend that worksite modifications are not a primary prevention for carpal tunnel syndrome in the working population. The clinical documentation submitted for review does not specifically identify that the injured worker's symptoms are exacerbated by work duties. Therefore, the need for worksite modification is not clearly supported. As such, the requested ergonomic evaluation of work station is not medically necessary or appropriate.

OS4 home unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Interferential Current Stimulation (ICS)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit, Galvanic Stimulation, Interferential Current Stimulation (ICS), Neuromuscular electri.

Decision rationale: The requested OS4 home unit is not medically necessary or appropriate. This is a combination unit that contains a NMES unit, a galvanic unit, an interferential unit, and a TENS unit. The California Medical Treatment Utilization Schedule does not support the use of galvanic stimulation. Additionally, the use of an NMES unit is primarily for rehabilitation of stroke victims and is not recommended for chronic pain. The use of an inferential unit is only recommended for patients who have failed all other types of chronic pain management to include the use of a TENS unit. The California Medical Treatment Utilization Schedule recommends the use of a TENS unit in conjunction with active therapy after a 30 day trial produces significant functional improvements. There is no documentation that the patient has undergone a 30 day trial of a TENS unit. Additionally, as the combination unit contains stimulation that is not supported by guideline recommendations the unit in its entirety would not be supported. As such, the requested OS4 home unit is not medically necessary or appropriate.

LSO Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ACOEM), 2nd Edition, (2004) 12, page(s) 310

Decision rationale: The requested LSO brace is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does not recommend the use of

a back brace beyond the acute phase of an injury. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. As such, the requested LSO brace is not medically necessary or appropriate.