

<b>Case Number:</b>	CM14-0148974		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	10/12/2009
<b>Decision Date:</b>	04/24/2015	<b>UR Denial Date:</b>	09/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/12/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 41 year old female who sustained an industrial injury on 10/12/2009. Recently she reported numbness and tingling in both wrists/hands, and bilateral shoulder pain with pushing. The injured worker has been diagnosed with, and/or impressions were noted to include, cervical, lumbar and thoracic sprain/strain; lumbago, possible lumbar occult spondylolisthesis; bilateral shoulder impingement and bursitis; internal derangement of the right shoulder; and bilateral wrist sprain/strain with median nerve neuritis and possible carpal tunnel syndrome. Treatments to date have included consultations; magnetic resonance imaging - lumbar (2/25/10) and right and left shoulder (8/27/10); ultrasound and Doppler study of the left wrist; and medication management. The history notes complaints that include pain and stiffness to the: neck, bilateral shoulders, wrists and hands, lumbar spine, and right knee, that she had been classified as temporarily totally disabled and had not worked since 10/2009, and that she was released to full and customary duties on 8/26/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**X-ray of the bilateral wrist and shoulders:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 267-268, 272, 207-208.

**Decision rationale:** Regarding the request for x-rays of the wrist, California MTUS supports x-rays for red flag conditions such as fracture, dislocation, and osteoarthritis or after a 4-6 weeks period of conservative treatment. They recommend against routine use for evaluation of forearm, wrist, and hand conditions. Within the documentation available for review, there is documentation that the patient is beyond 4-6 weeks of conservative treatment. However, other conservative measures are being sought and a wrist steroid injection was certified. Given this, the patient should be monitored for outcome follow wrist injection first, and it is unclear how x-rays before this conservative treatment would alter the management plan. Regarding x-rays of the shoulder, the ACOEM guidelines also similar specify for a period of conservative treatment. Again in this case, injection of the shoulder has been certified and should be carried out and assessed before imaging is appropriate. Imaging should be ordered at a later date after assessment and if there was limited benefit of steroid injections. The request for x-rays is not medically necessary.

**Back Brace:** 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): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar Supports.

**Decision rationale:** In the case of this request for back brace, evidence-based guidelines do not recommend lumbar bracing in general. There is a paucity of evidence to recommend lumbar bracing for the treatment or prevention of low back pain. The conditions which warrant lumbar bracing include spine instability or in the postoperative period following lumbar spine surgery. In this injured worker, a review of the medical records indicates chronic low back pain, but no evidence of instability such as significant displacement in flexion-extension x-rays. Given this, this request is not medically necessary.