

<b>Case Number:</b>	CM14-0192567		
<b>Date Assigned:</b>	11/26/2014	<b>Date of Injury:</b>	04/30/2012
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	10/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2014

### 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: Pennsylvania

Certification(s)/Specialty: Internal Medicine, Hospice & Palliative Medicine

### 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 61-year-old woman with a date of injury of 04/30/2012. A treating physician note dated 09/26/2014 identified the mechanism of injury as repetitive work resulting in lower back, right wrist, and right shoulder injuries. This note and a treating physician note dated 10/06/2014 indicated the worker was experiencing numbness and tingling in the right wrist and pain in the lower back that went into the right leg, right knee, and right shoulder. Documented examinations described lower back muscle spasm with decreased motion in the lower back joints, positive kemp's testing, unspecified signs of right hip tendonitis, and unspecified symptoms in the sacroiliac and right shoulder regions. The submitted and reviewed documentation concluded the worker was suffering from carpal tunnel syndrome, mid- and lower back radiculitis, lower back strain/sprain, wrist strain/sprain, and shoulder impingement with strain/sprain. Treatment recommendations included medications and urinary drug screen testing. A Utilization Review decision was rendered on 10/22/2014 recommending non-certification for twice weekly sessions of acupuncture for four weeks and for a lower back brace, a work hardening program with extra hours, two sets of shoulder x-rays, MRI of the lower back and right shoulder, a functional capacity evaluation, an EMG/NCV of both arms and legs, a single point cane, x-rays of the lumbar spine, consultation with a "cardiorespiratory" specialist, and massage therapy sessions three times weekly for four weeks with additional supportive services for a prior date(s) of service that was unspecified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Acupuncture 2 times per week for 4 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The MTUS Guidelines recommend the use of acupuncture when pain medication is not tolerated or can be reduced with this treatment. It can also be used alongside rehabilitation and/or surgery to speed recovery. Some accepted goals include a decreased pain level, improved nausea caused by pain medications, increased range of joint motion, improved relaxation with anxiety, and reduced muscle spasms. Acupuncture treatment can include the use of electrical stimulation. Functional improvement is expected within three to six treatments. The Guidelines support having acupuncture treatments one to three times weekly for up to one to two months. The submitted and reviewed documentation indicated the worker was experiencing numbness and tingling in the right wrist and pain in the lower back that went into the right leg, right knee, and right shoulder. There was no discussion indicating the reason this therapy was needed or describing the planned goals. Further, the requested number of sessions is more than those supported by the Guidelines, and there was no description of special circumstances that would sufficiently support this. In the absence of such evidence, the current request for twice weekly sessions of acupuncture for four weeks is not medically necessary.

**Retrospective request for MRI right shoulder (unknown DOS): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 196, 207-209, and 214 (Table 9-6).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-219.

**Decision rationale:** The MTUS Guidelines recommend the use of acupuncture when pain medication is not tolerated or can be reduced with this treatment. It can also be used alongside rehabilitation and/or surgery to speed recovery. Some accepted goals include a decreased pain level, improved nausea caused by pain medications, increased range of joint motion, improved relaxation with anxiety, and reduced muscle spasms. Acupuncture treatment can include the use of electrical stimulation. Functional improvement is expected within three to six treatments. The Guidelines support having acupuncture treatments one to three times weekly for up to one to two months. The submitted and reviewed documentation indicated the worker was experiencing numbness and tingling in the right wrist and pain in the lower back that went into the right leg, right knee, and right shoulder. There was no discussion indicating the reason this therapy was needed or describing the planned goals. Further, the requested number of sessions is more than those supported by the Guidelines, and there was no description of special circumstances that would sufficiently support this. In the absence of such evidence, the current request for twice weekly sessions of acupuncture for four weeks is not medically necessary.

**Retrospective request for massage therapy 3x4 weeks - ultrasound, neuromuscular rehab, electrical stimulation, therapeutic exercises, joint stabilization (unknown DOS): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manipulation and Education.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage; Physical Medicine; Transcutaneous Electrotherapy Page(s): 60; 98-99; 114-117.

**Decision rationale:** The MTUS Guidelines discuss massage therapy as an option along with other recommended treatments, such as exercise, and it should be limited to four to six visits. Massage is a passive intervention and treatment dependence should be avoided. The limited scientific studies available show contradictory results of benefit. Transcutaneous electrical nerve stimulation (TENS) applies electricity to the surface of the skin to improve pain control. The MTUS Guidelines support its use in managing some types of chronic pain and in acute pain for up to thirty days after surgery. TENS is recommended as a part of a program of evidence-based functional restoration for specific types of neuropathic pain, spasticity with spinal cord injuries, and multiple sclerosis-related pain and/or muscle spasm. The MTUS Guidelines support the use of physical therapy, especially active treatments, based on the philosophy of improving strength, endurance, function, and pain intensity. This type of treatment may include supervision by a therapist or medical provider. The worker is then expected to continue active therapies at home as a part of this treatment process in order to maintain the improvement level. Decreased treatment frequency over time ("fading") should be a part of the care plan for this therapy. The Guidelines support specific frequencies of treatment and numbers of sessions depending on the cause of the worker's symptoms. Related passive treatments are not independently recommended by the Guidelines, and there is limited research to support them. The submitted and reviewed records concluded the worker was suffering from carpal tunnel syndrome, mid- and lower back radiculitis, lower back strain/sprain, wrist strain/sprain, and shoulder impingement with strain/sprain. There was no discussion describing the goals of these treatments, supporting a need for therapist-directed rehabilitation sessions, detailing the above recommended criteria, or describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for massage therapy sessions three times weekly for four weeks with ultrasound, neuromuscular rehabilitation, electrical stimulation, therapeutic exercises, and joint stabilization for a prior date of service that was unspecified is not medically necessary.

**Retrospective request for consultation with cardiorespiratory (unknown DOS): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, 2nd edition (2004): chapter 7, page 127

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Outcomes and Endpoints Page(s): 8.

**Decision rationale:** The MTUS Guidelines generally encourage follow up care when needed to maximize the worker's function. The submitted and reviewed records concluded the worker was suffering from carpal tunnel syndrome, mid- and lower back radiculitis, lower back strain/sprain, wrist strain/sprain, and shoulder impingement with strain/sprain. There was no discussion clarifying the type of specialist whose opinion would be helpful or sufficiently supporting the reason(s) this consultation was requested. In the absence of such evidence, the current request for consultation with a "cardiorespiratory" specialist for a prior date of service that was unspecified is not medically necessary.

**Retrospective request for x-ray lumbar spine (unknown DOS):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Integrated Treatment/Disability Duration Guidelines, Low Back- Lumbar & Thoracic (Acute & Chronic), Radiography (X-rays)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-366.

**Decision rationale:** The MTUS Guidelines support the use of x-rays of the lower back when evaluation shows "red flags" for a potential broken bone, cancer, or infection, especially when the "red flag(s)" remains after a month of treatment. "Red flags" for a potential broken bone include findings such as a history of major trauma (such as falling from a height or a vehicle accident), minor trauma involving someone at higher risk for low bone density, or examination shows tenderness over a specific spine bone. The submitted and reviewed documentation concluded the worker was suffering from carpal tunnel syndrome, mid- and lower back radiculitis, lower back strain/sprain, wrist strain/sprain, and shoulder impingement with strain/sprain. There was no documentation of a recent trauma or description of a finding concerning as a "red flag" or any of the other above concerning issues. For these reasons, the current request for x-rays of the lumbar spine for a prior date of service that was unspecified is not medically necessary.

**Retrospective request for EMG/NCV of bilateral lower extremities (unknown DOS):**  
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 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 165-188; 261; 287-326;.

**Decision rationale:** The MTUS Guidelines support electromyography (EMG) of the legs when the worker is experiencing lower back pain and subtle, focal neurologic issues lasting longer than a month. This testing is recommended to clarify nerve root dysfunction, especially when a bulging lower back disk is suspected. This testing is not recommended for clinically obvious radiculopathy. The MTUS Guidelines recommend the use of nerve conduction velocity (NCV)

testing to identify subtle focal neurologic dysfunction in those with neck and/or arm symptoms and to help separate carpal tunnel syndrome from other conditions, such as cervical radiculopathy. There was no description of subtle, focal neurologic issues, and there was no discussion detailing special circumstances that sufficiently supported the request for these tests. In the absence of such evidence, the current request for an electromyography (EMG) and nerve conduction velocity (NCV) testing of both legs for a prior date of service that was unspecified is not medically necessary.

**Retrospective request for single point cane (unknown DOS): 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), Integrated Treatment/Disability Duration Guidelines, Knee & Leg (Acute & Chronic), Walking aids

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Hoenig H, et al. Overview of geriatric rehabilitation: Program components and settings for rehabilitation. Topic 16852, version 7.0. UpToDate. Accessed 02/09/2015.

**Decision rationale:** The MTUS Guidelines are silent on this issue in this clinical situation. Mobility devices may be used for physical limitations affecting mobility, such as weakness, problems with balance, limited endurance, and/or sensory issues. Devices are intended to improve mobility and independence and to provide some protection against falls. However, there is limited research on the impact of these devices. Canes require good hand and arm strength to use them safely and provide only minimal support. Canes are most effective when the walking problem is minimal and/or involves an issue on only one side. The submitted and reviewed documentation concluded the worker was suffering from carpal tunnel syndrome, mid- and lower back radiculitis, lower back strain/sprain, wrist strain/sprain, and shoulder impingement with strain/sprain. There was no discussion suggesting the worker's problem with walking was minimal or that it involved only one side. Further, there was an indication the worker had conditions that could potentially affect hand and arm strength. For these reasons, the current request for a single point cane for a prior date of service that was unspecified is not medically necessary.

**Retrospective request for EMG/NCV of bilateral upper extremities (unknown DOS): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neck and Upper Back Complaints; Forearm, Wrist, and Hand Complaints Page(s): 165-188;261.

**Decision rationale:** The MTUS Guidelines recommend the use of electromyography (EMG) to identify subtle focal neurologic dysfunction in those with neck and/or arm symptoms; to clarify nerve root dysfunction in cases when a bulging disc in the upper spine is suspected before treatment with surgery; in the diagnosis of nerve root problems when the documented history, examination, and imaging studies are inconsistent; and to help separate carpal tunnel syndrome from other conditions, such as cervical radiculopathy. The MTUS Guidelines recommend the use of nerve conduction velocity (NCV) studies to identify subtle focal neurologic dysfunction in those with neck and/or arm symptoms and to help separate carpal tunnel syndrome from other conditions, such as cervical radiculopathy. The submitted and reviewed documentation concluded the worker was suffering from carpal tunnel syndrome, mid- and lower back radiculitis, lower back strain/sprain, wrist strain/sprain, and shoulder impingement with strain/sprain. The documented examinations did not describe abnormal neurologic findings. There was no discussion suggesting any of the above scenarios or describing special circumstances that would support the use of these studies in this setting. In the absence of such evidence, the current request for electromyography (EMG) and nerve conduction velocity (NCV) studies of both arms for a prior date of service that was unspecified is not medically necessary.

**Retrospective request for functional capacity evaluation (unknown DOS): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), FCE

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 21-22; 80-83.

**Decision rationale:** The ACOEM Guidelines support the use of a functional capacity evaluation (FCE) if it is necessary to translate a medical problem into functional limits and/or to determine a worker's capacity to perform work duties. This more precise and detailed assessment is not needed in every case. The submitted and reviewed documentation concluded the worker was suffering from carpal tunnel syndrome, mid- and lower back radiculitis, lower back strain/sprain, wrist strain/sprain, and shoulder impingement with strain/sprain. These records did not contain a discussion sufficiently detailing the reason(s) a functional capacity evaluation was needed in this case or documentation of special circumstances that would otherwise sufficiently support this request. In the absence of such evidence, the current request for a functional capacity evaluation for a prior date of service that was unspecified is not medically necessary.

**Retrospective request for MRI of the lumbar spine (unknown DOS): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287 and 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-326.

**Decision rationale:** The ACOEM Guidelines recommend reserving advanced imaging of the lumbar spine with MRI for those with clear objective examination findings identifying specific nerve compromise when the symptoms and findings do not respond to treatment with conservative management for at least a month and when surgery remains a treatment option. These Guidelines also encourage that repeat advanced imaging should be limited to those with newly worsened or changed signs and symptoms. The submitted and reviewed documentation concluded the worker was suffering from carpal tunnel syndrome, mid- and lower back radiculitis, lower back strain/sprain, wrist strain/sprain, and shoulder impingement with strain/sprain. Documented examinations and assessments did not consistently identify a specific nerve that was compromised, and there was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for a MRI of the lumbar region for a prior date of service that was unspecified is not medically necessary.

**Retrospective request for x-ray of the right shoulder (unknown DOS): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Integrated Treatment/Disability Duration Guidelines, Shoulder (Acute & Chronic), Radiography

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-219.

**Decision rationale:** The ACOEM Guidelines support the use of x-rays for repeated shoulder dislocations, to confirm the diagnosis of partial rotator cuff tears if necessary, and to evaluate the possible presence of a tumor or infection involving the shoulder bones if "red flags" are present. X-rays are not recommended for typical cases of shoulder impingement syndromes because these cases are managed in the same way, regardless of x-ray findings. The submitted and reviewed documentation concluded the worker was suffering from carpal tunnel syndrome, mid- and lower back radiculitis, lower back strain/sprain, wrist strain/sprain, and shoulder impingement with strain/sprain. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for right shoulder x-rays for a prior date of service that was unspecified is not medically necessary.

**Retrospective request for x-ray of the right shoulder (unknown DOS): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Integrated Treatment/Disability Duration Guidelines, Shoulder (Acute & Chronic), Radiography

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-219.

**Decision rationale:** The ACOEM Guidelines support the use of x-rays for repeated shoulder dislocations, to confirm the diagnosis of partial rotator cuff tears if necessary, and to evaluate the possible presence of a tumor or infection involving the shoulder bones if "red flags" are present. X-rays are not recommended for typical cases of shoulder impingement syndromes because these cases are managed in the same way, regardless of x-ray findings. The submitted and reviewed documentation concluded the worker was suffering from carpal tunnel syndrome, mid- and lower back radiculitis, lower back strain/sprain, wrist strain/sprain, and shoulder impingement with strain/sprain. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for right shoulder x-rays for a prior date of service that was unspecified is not medically necessary.

**Retrospective request for work hardening and work conditioning + extra time per hour 24 hr (unknown DOS):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning, Work hardening. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine; Work Conditioning/Work Hardening Page(s): 98-99; 125-126.

**Decision rationale:** The MTUS Guidelines support the use of physical therapy, especially active treatments, based on the philosophy of improving strength, endurance, function, and pain intensity. This type of treatment may include supervision by a therapist or medical provider. The worker is then expected to continue active therapies at home as a part of this treatment process in order to maintain the improvement level. The Guidelines also support the use of work hardening programs for appropriate workers. Some criteria include the worker's position has a medium or higher demand level, the injury occurred within the last two years, physical therapy resulted in improvement followed by a plateau without an expectation of additional benefit, the worker is healthy and vigorous enough to complete the program within four weeks and to participate in at least four hours of treatment three to five days per week, and the employer and worker have a specifically defined goal of returning to work. The submitted and reviewed documentation concluded the worker was suffering from carpal tunnel syndrome, mid- and lower back radiculitis, lower back strain/sprain, wrist strain/sprain, and shoulder impingement with strain/sprain. There was no discussion detailing the criteria recommended by the Guidelines or describing special circumstances that sufficiently supported the use of this treatment in this setting. In the absence of such evidence, the current request for a work hardening and conditioning program with extra time per hour 24 hours for a prior date of service that was unspecified is not medically necessary.

**Retrospective request for lumbar 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: Integrated Treatment/Disability Duration Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic)

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

**Decision rationale:** The MTUS Guidelines recommend the use of lower back support braces after a recent injury to the lower back causing pain or a recent flare of pain symptoms. Education and encouragement of proper body positioning during activities and/or lifting is superior to the use of braces. Research has not shown lower back braces to have a lasting benefit beyond the earliest phase of symptom relief. The submitted and reviewed documentation concluded the worker was suffering from carpal tunnel syndrome, mid- and lower back radiculitis, lower back strain/sprain, wrist strain/sprain, and shoulder impingement with strain/sprain. There was no discussion detailing special circumstances that sufficiently supported the use of this treatment in this setting. In the absence of such evidence, the current request for a lumbar brace for a prior date of service that was unspecified is not medically necessary.