

Case Number:	CM15-0103487		
Date Assigned:	06/09/2015	Date of Injury:	08/16/2013
Decision Date:	09/29/2015	UR Denial Date:	04/30/2015
Priority:	Standard	Application Received:	05/29/2015

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: Preventive Medicine, Occupational 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 49 year old female, who sustained an industrial injury on 08/16/2013. She has reported injury to the neck and bilateral wrists. The diagnoses have included bilateral wrists sprain/strain; cervical sprain/strain; cervical radiculopathy. Treatment to date has included medications, diagnostics, bracing, acupuncture, chiropractic therapy, physical therapy, and home exercises. Medications have included Ibuprofen, Tramadol, Naproxen, and topical compounded cream. A progress note from the treating physician, dated 09/19/2014, documented a follow-up visit with the injured worker. The injured worker reported constant bilateral wrist and hand pain, left is greater than right; pain is rated 2-7/10 on the visual analog scale with medications; constant neck pain radiating to the bilateral upper extremities, and is associated with numbness, tingling, and weakness; pain is rated 5-6/10 on the visual analog scale, and 0-3/10 with medications. Objective findings included pain and tenderness noted over the cervical spine area; decreased cervical spine range of motion, with pain in all motions; tenderness noted over bilateral wrist/hand area; orthopedic testing reveals positive Tinel's sign and Phalen's test bilaterally, left greater than right; and decreased ranges of motion to the bilateral wrists/hands. Retrospective requests are being made for internal medicine consult, date of service: 10/15/13; TENS (transcutaneous electrical nerve stimulation) unit with 6 month supply x 4, date of service: 10/16/13; 1 thumb spica, date of service: 10/16/13; electric heat pad, date of service: 10/16/13; 1 tech fit, date of service: 10/16/13; 16 chiro therapy treatments, dates of service: 10/09/13 and 03/28/14; 15 acupuncture sessions, dates of service: 10/14/13 and 01/27/14; 16 occupational therapy sessions, dates of service: 10/17/13 and 05/22/14; and 1 extracorporeal shock wave therapy (ESWT), date of service: 10/03/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Internal medicine consult Date of service: 10/15/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 254.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7, Independent Medical Examinations and Consultations, page 132.

Decision rationale: According to the MTUS, a referral request should specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, workability, clinical management, and treatment options. The medical record lacks sufficient documentation and does not support a referral request. Retrospective Internal medicine consult is not medically necessary.

Retrospective TENS unit with 6 month supply x4, Date of service: 10/16/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) Page(s): 113-117.

Decision rationale: The MTUS does not recommend a TENS unit as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. There is no documentation that a trial period with a rented TENS unit has been completed. Retrospective TENS unit with 6 month supply x4 is not medically necessary.

Retrospective 1 Thumb spica, Date of service: 10/16/13: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist, & Hand (Acute and Chronic): Immobilization (treatment).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), Splints.

Decision rationale: The Official Disability Guidelines recommend splinting of wrist in neutral position at night & day prn, as an option in conservative treatment. Use of daytime wrist splints has positive, but limited evidence. Splinting after surgery has negative evidence. Data suggest that splinting is most effective if applied within three months of symptom onset. This systematic review found that the usefulness of splinting as initial treatment for improving symptoms is still supported by recent literature, but these effects are temporary. The splint was provided within the three-month window recommended by the ODG. I am reversing the previous utilization review decision. Retrospective 1 Thumb spica is medically necessary.

Retrospective Electric heat pad, Date of service: 10/16/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist, & Hand (Acute and Chronic): Heat therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), Heat Therapy.

Decision rationale: The Official Disability Guidelines do not recommended electric heat pads over other heat therapies. Where heating is desirable, providers may consider a limited trial of heat therapy for treatment of acute sprains, but only if used as an adjunct to a program of evidence-based conservative care (exercise). Heat therapies have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Based on the patient's stated date of injury, the acute phase of the injury has passed. Retrospective Electric heat pad is not medically necessary.

Retrospective 1 Tech fit, Date of service: 10/16/13: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross Clinical UM Guideline, Durable Medical Equipment, Guideline #: CG-DME-10, Last Review Date: 02/13/2014.

Decision rationale: According to the Blue Cross Clinical UM Guideline for Durable Medical Equipment, durable medical equipment is considered medically necessary when all of a number of criteria are met including:- There is a clinical assessment and associated rationale for the requested DME in the home setting, as evaluated by a physician, licensed physical therapist, occupational therapist, or nurse; and- There is documentation substantiating that the DME is clinically appropriate, in terms of type, quantity, frequency, extent, site and duration and is considered effective for the individual's illness, injury or disease; and- The documentation supports that the requested DME will restore or facilitate participation in the individual's usual IADL's and life roles. The information should include the individual's diagnosis and other pertinent functional information including, but not limited to, duration of the individual's

condition, clinical course (static, progressively worsening, or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The medical record does not contain sufficient documentation or address the above criteria. Retrospective 1 Tech fit, Date of service: 10/16/13 is not medically necessary.

Retrospective for 16 Chiro therapy treatments, Dates of service: 10/9/13 and 3/28/14:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

Decision rationale: The request is for 16 visits of chiropractic. The Chronic Pain Medical Treatment Guidelines allow for an initial 4-6 visits after which time there should be documented functional improvement prior to authorizing more visits. The request for 16 chiropractic visits is more than what is medically necessary to establish whether the treatment is effective. The first reviewer modified the request to 6 visits only. Retrospective for 16 Chiro therapy treatments is not medically necessary.

Retrospective for 15 Acupuncture sessions, Dates of service: 10/14/13 and 1/27/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The Acupuncture Medical Treatment Guidelines state that the initial authorization for acupuncture is for 3-6 treatments. Authorization for more than 6 treatments would be predicated upon documentation of functional improvement. The request for 15 treatments is greater than the number recommended for a trial to determine efficacy. Retrospective for 15 Acupuncture sessions is not medically necessary.

Retrospective for 16 Occupational therapy sessions, Dates of service: 10/17/13 and 5/22/14:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

Decision rationale: The MTUS allows for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Prior to full authorization, therapeutic physical therapy is authorized for trial of 6 visits over 2 weeks, with evidence of

objective functional improvement prior to authorizing more treatments. There is no documentation of objective functional improvement and the request is for greater than the number of visits necessary for a trial to show evidence of objective functional improvement prior to authorizing more treatments. Retrospective for 16 Occupational therapy session is not medically necessary.

Retrospective for 1 Extracorporeal shock wave therapy (ESWT), Date of service: 10/3/13:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), Extracorporeal Shock Wave Therapy.

Decision rationale: Limited evidence exists regarding extracorporeal shock wave therapy (ESWT) in reducing pain and improving function. While it appears to be safe, there is disagreement as to its efficacy. Insufficient high quality scientific evidence exists to determine clearly the effectiveness of this therapy. Retrospective for 1 Extracorporeal shock wave therapy (ESWT) is not medically necessary.