

Case Number:	CM15-0189262		
Date Assigned:	10/01/2015	Date of Injury:	03/19/2015
Decision Date:	12/08/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	09/25/2015

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: Indiana, 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 March 19, 2015. The injured worker was diagnosed as having cervical spine discopathy, lumbar discopathy, thoracic spine sprain and strain, right shoulder sprain and strain, right elbow sprain and strain, right wrist and hand sprain and strain with tendinitis, and right shoulder tear. Treatment and diagnostic studies to date has included psychotherapy, medication regimen, functional capacity evaluation, x-ray of the right shoulder, x-ray of the right elbow, x-ray of the right forearm, nocturnal polysomnogram, x-rays of the cervical spine, the lumbar, the right shoulder, and the right wrist, magnetic resonance imaging of the lumbar spine, magnetic resonance imaging of the right shoulder, magnetic resonance imaging of the cervical spine, magnetic resonance imaging of the right wrist, and electromyogram with nerve conduction study of the bilateral upper extremities. In a progress note dated July 03, 2015 the treating physician reports complaints of pain to the cervical spine that radiates to the right shoulder, pain to the thoracic spine, the lumbar spine, the right shoulder, the bilateral elbows, the right wrist, the right hand, and the right lower extremity, along with headaches, numbness, and sleep disorder. Examination performed on July 03, 2015 was revealing for "moderate" tenderness to the above listed areas of pain, "prior positive magnetic resonance imaging results", "positive electromyogram tests", "positive orthopedic testing", and decreased range of motion. The injured worker's pain level on July 03, 2015 was rated a 7 to 8 out of 10 to the cervical spine, 6 to 7 out of 10 to the right shoulder and left elbow, a 4 to 5 out of 10 to the thoracic spine, 8 to 9 out of 10 to the lumbar spine, 6 out of 10 to the right wrist and right hand, and a 4 out of 10 to the right elbow. The progress note on July 03, 2015 did not include any prior treatments or

therapies performed to the injured worker along with the lack of documentation of results from prior treatments and therapies. The treating physician requested a purchase of a cervical pillow, a purchase of a lumbosacral orthosis, a purchase of a Bio Touch muscle stimulator, and a purchase of a right wrist brace. On August 28, 2015 the Utilization Review determined the requests for a purchase of a cervical pillow, a purchase of a lumbosacral orthosis, a purchase of a Bio Touch muscle stimulator, and a purchase of a right wrist brace to be non-approved.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical pillow, purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back - pillow.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Neck and Upper Back; pillow.

Decision rationale: MTUS is silent on this, but ODG states: "Recommend use of a neck support pillow while sleeping, in conjunction with daily exercise. This RCT concluded that subjects with chronic neck pain should be treated by health professionals trained to teach both exercises and the appropriate use of a neck support pillow during sleep; either strategy alone did not give the desired clinical benefit." There is no documentation that a health professional has trained or is planning to train the employee on exercises for the neck, and so the pillow alone will not give benefit. Therefore, the request is not medically necessary.

Lumbosacral orthosis, purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): General Approach, Initial Assessment, Medical, Physical Examination, Diagnostic Criteria, Work-Relatedness, Initial Care, Physical Methods, Activity, Work, Follow-up Visits, Special Studies, Surgical Considerations, Summary, References. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (Lumbar and Thoracic), Lumbar Support.

Decision rationale: ACOEM states, Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states, not recommended for prevention. Recommended as an option for treatment. See below for indications. Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. (Jellema-Cochrane, 2001) (Van Poppel, 1997) (Linton, 2001) (Assendelft-Cochrane, 2004) (Van Poppel, 2004) (Resnick, 2005) Lumbar supports do not prevent LBP. (Kinkade, 2007) A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective and

other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. (Bigos, 2009) This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. (van Duijvenbode, 2008). ODG states for use as a treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). The patient is beyond the acute phase of treatment and the treating physician has provided no documentation of spondylolisthesis or documented instability. As such the request for LUMBAR SACRAL ORTHOSIS BRACE is not medically necessary.

Bio Touch muscle stimulator, purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, TENS chronic pain (transcutaneous electrical nerve stimulation).

Decision rationale: Bio Touch is similar to a TENS unit. MTUS states regarding TENS unit, Not recommended 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, for the conditions described below. For pain, MTUS and ODG recommend TENS (with caveats) for neuropathic pain, phantom limb pain and CRPSII, spasticity, and multiple sclerosis. The medical records do not indicate any of the previous conditions. ODG further outlines recommendations for specific body parts: Low back: Not recommended as an isolated intervention. Knee: Recommended as an option for osteoarthritis as adjunct treatment to a therapeutic exercise program. Neck: Not recommended as a primary treatment modality for use in whiplash-associated disorders, acute mechanical neck disease or chronic neck disorders with radicular findings. Ankle and foot: Not recommended Elbow: Not recommended Forearm, Wrist and Hand: Not recommended Shoulder: Recommended for post-stroke rehabilitation. Medical records do not indicate conditions of the low back, knee, ankle, elbow, or shoulders that meet guidelines. Of note, medical records do not indicate knee osteoarthritis. ODG further details criteria for the use of TENS for Chronic intractable pain (for the conditions noted above): (1) Documentation of pain of at least three months duration. (2) There is evidence that other appropriate pain modalities have been tried (including medication) and failed. (3) A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. (4) Other ongoing pain treatment should also be documented during the trial period including medication usage. (5) A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. (6) After a successful 1-month trial, continued TENS treatment may be recommended if the physician documents that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. At this point

purchase would be preferred over rental. (7) Use for acute pain (less than three months duration) other than post-operative pain is not recommended. (8) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. The medical records do not satisfy the several criteria for selection specifically, lack of documented 1-month trial, lack of documented short-long term treatment goals with unit, and unit use for acute (less than three months) pain. As such, the request is not medically necessary.

Wrist brace, Right, purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): General Approach, Initial Assessment, Medical History, Physical Examination, Diagnostic Criteria, Work-Relatedness, Initial Care, Physical Methods, Job Analysis, Work Activities, Follow-up Visits, Special Studies, Surgical Considerations, Summary, References. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm Wrist Hand, Splint.

Decision rationale: MTUS is silent with regards to wrist brace. ACOEM states regarding wrist immobilization, Splinting of wrist in neutral position at night & day may be indicated for carpal tunnel syndrome and Limit motion of inflamed structures with wrist and thumb splint. ACOEM further states Limit motion of inflamed structures for tendinitis and tenosynovitis, but does not specify with splinting. Medical records do not indicate a diagnosis of carpal tunnel syndrome. Additionally, the wrist pain described is not specific for tenosynovitis or tendinitis. ODG refers to splinting section for braces, Recommended for treating displaced fractures. Immobilization is standard for fracture healing although patient satisfaction is higher with splinting rather than casting. Following tendon repair: Recovery of finger function after primary extensor tendon repair depends on the complexity of trauma and the anatomical zone of tendon injury. Static splinting is an appropriate tool after primary extensor tendon repair in Verdan's zone 1, 2, 4 and 5, whereas injuries in zones 3 and 6 may demand for a different treatment regimen. Arthritis: A recent randomized controlled study concluded that prefabricated wrist working splints are highly effective in reducing wrist pain after 4 weeks of splint wearing in patients with wrist arthritis. For rheumatoid arthritis, there was generally a positive effect of splint use on hand function; however, perceived splint benefit was marginal. For most tasks splint use improved or did not change pain levels, did not interfere with work performance, increased or maintained endurance, and did not increase perceived task difficulty. Medical records do not indicate a displaced fracture, tendon repair, arthritis, rheumatoid arthritis of the wrists, which are possible indications for a wrist splint/brace. As such, the request for Wrist brace is not medically necessary.