

Case Number:	CM15-0195451		
Date Assigned:	10/09/2015	Date of Injury:	05/19/2014
Decision Date:	12/23/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	10/06/2015

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: Orthopedic Surgery

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 40 year old female who sustained an industrial injury on May 19, 2014. Of note, the initial report of illness dated May 19, 2014 reported 'will consider nerve conduction study if no response to physical therapy and or still complaining of paresthesias. Supporting documentation reported on May 19, 2014 radiographic study performed of right wrist and hand that showed no acute findings. On July 22, 2014 the worker noted undergoing EMG and nerve conduction study that revealed bilateral moderate carpal tunnel syndrome, right side worse. On April 25, 2015 she underwent MRI of left wrist showing bone cysts in the capitate bone, and subchondral erosion at the proximal articular surface of the lunate and triquetrum. A recent primary treating office visit dated September 14, 2015 reported subjective complaint of intermittent moderate sharp, neck pain and stiffness with numbness and tingling. There is also complaint of intermittent right wrist, and left wrist pain, weakness, and numbness with tingling. The following diagnoses were applied to the visit: cervical radiculopathy; cervical strain and sprain; right carpal tunnel syndrome; status post right carpal tunnel release and left carpal tunnel syndrome. The plan of care is with recommendation for physical therapy, acupuncture to decrease pain and spasm and increase range of motion and ADL's; orthopedic consultation discussing treatment options, invasive; and recommending a TENS unit for home use to control pain. Primary follow up dated April 10, 2015 reported the plan of care with requesting recommendation for physical therapy, acupuncture, MRI of cervical spine and wrists, nerve conduction study of bilateral upper extremities, and pending follow up. On September 14, 2015 a request was made for physical therapy, acupuncture, surgical consultation, TENS unit trial, and range of motion testing that were denied by Utilization Review on September 24, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy sessions, QTY: 6.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: CA MTUS/Chronic Pain Medical Treatment Guidelines, Physical Medicine, page 98-99 recommend the following for non-surgical musculoskeletal conditions: Physical Medicine Guidelines: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine; Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2): 8-10 visits over 4 weeks. In this case there is insufficient evidence as to why the patient cannot be placed on a home based program. It is unclear how many visits of therapy have been completed after the industrial injury of 5/19/14. Therefore the request is not medically necessary.

Acupuncture sessions, QTY: 6.00: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: Per the MTUS Acupuncture Medical Treatment Guidelines, pages 8 and 9: Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(ef). The guidelines specifically report 3-6 treatments initially. In this case there is insufficient evidence of prior response to acupuncture or prior amounts performed from the exam of 9/14/15. Therefore the request is not medically necessary.

Ortho surgical consultation for C/S, wrists: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Independent Medical Examinations and Consultations, Chapter 7.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: Per the CA MTUS/ACOEM guidelines, Chapter 11, Forearm, Wrist and Hand Complaints, page 270, Referral for hand surgery consultation may be indicated for patients who: Have red flags of a serious nature; Fail to respond to conservative management, including work site modifications; Have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention. Surgical considerations depend on the confirmed diagnosis of the presenting hand or wrist complaint. If surgery is a consideration, counseling regarding likely outcomes, risks and benefits, and, especially, expectations is very important. If there is no clear indication for surgery, referring the patient to a physical medicine practitioner may aid in formulating a treatment plan. In this case the exam note from 9/14/15 does not demonstrate any evidence of red flag condition or clear lesion shown to benefit from surgical intervention. Therefore the request is not medically necessary.

Duet stim TENS/EMS neurostimulator trial (x1 month): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: According to the California MTUS Chronic Pain Medical Treatment Guideline regarding TENS, pages 113-114, chronic pain (transcutaneous electrical nerve stimulation) is 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 neuropathic pain and CRPS II and for CRPS I (with basically no literature to support use). Criteria for the use of TENS: Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. There is evidence that other appropriate pain modalities have been tried (including medication) and failed. 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. In this case there is insufficient evidence of chronic neuropathic pain from the exam note of 9/14/15 to warrant a TENS unit. There also is no evidence of an evidence based functional restoration plan. Therefore the request is not medically necessary.

Range of motion (ROM) test 1x month per doctor's visit: 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) Pain, Office visits.

Decision rationale: CA MTUS/ACOEM is silent on office visits. According to the ODG Pain section, Office visits; Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. In this case there is lack of rationale from 9/14/15 why range of motion testing should be a separate procedure code other than routine evaluation and management office visit. Therefore the request is not medically necessary.