

Case Number:	CM15-0202559		
Date Assigned:	10/19/2015	Date of Injury:	05/29/2015
Decision Date:	12/04/2015	UR Denial Date:	10/05/2015
Priority:	Standard	Application Received:	10/14/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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 43 year old male, who sustained an industrial injury on 5-29-2015. The injured worker is undergoing treatment for: neck, back, shoulders, and hands due to repetitive activities. On 9-21-2015, he reported low back pain with radiation into the right leg, neck pain with pins and needles and popping sensations, upper back pain, bilateral shoulder pain with pins and needles sensation, radiating bilateral hand and wrist pain with numbness and tingling sensations. Objective findings revealed decreased sensory at L5-S1 and left Ct-C7, decreased thoracolumbar range of motion, decreased neck range of motion, decreased bilateral shoulder and bilateral wrists ranges of motion. The treatment and diagnostic testing to date has included: medications, emergency room treatment, injection (5-29-15), ice pack. Medications have included: none documented. Current work status: modified. The request for authorization is for: chiropractic manipulation and therapy, one month home based trial of neurostimulator TENS-EMS with supplies, occupational medicine evaluation and treatment, sleep study, psychiatric treatment, x-ray of the cervical spine, x-ray of the thoracic spine, x-ray of the lumbar spine, x-ray of the left shoulder, x-ray of the right shoulder, x-rays of the left hand and wrist, x-ray of the right hand and wrist, support for lumbar spine, and supports for wrists. The UR dated 10-5-2015: non-certified the requests for chiropractic manipulation and therapy, one month home based trial of neurostimulator TENS-EMS with supplies, occupational medicine evaluation and treatment, sleep study, psychiatric treatment, x-ray of the cervical spine, x-ray of the thoracic spine, x-ray of the lumbar spine, x-ray of the left shoulder, x-ray of the right shoulder, x-rays of the left hand and wrist, x-ray of the right hand and wrist, support for lumbar spine, and supports for wrists.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic manipulation and therapy QTY 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: According to the CA MTUS/ACOEM guidelines, Manual Therapy or Chiropractic manipulation is a treatment option during the acute phase of injury, and manipulation should not be continued for more than a month, particularly when there is not a good response to treatment. The MTUS states that is recommended for chronic pain if it is caused by musculoskeletal conditions. The intended goal or effect is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The ODG states that cervical manipulation may be a treatment option for patients with occupationally related neck pain or cervicogenic headache. The ODG recommends up to 18 total chiropractic and massage visits over 6-8 weeks for cervical and thoracic injuries with evidence of functional improvement after a 6 visit initial trial. For the treatment of low back pain, a trial of 6 visits is recommended over 2 weeks, with evidence of objective improvement, with a total of up to 18 visits over 6-8 weeks. If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. In this case, an occupational medicine consult has been approved and physical therapy has not been attempted. In addition, the requested number of chiropractic sessions exceed the MTUS recommendation. Medical necessity for the requested Chiropractic manipulation and treatment (12 sessions) has not been established. The requested services are not medically necessary.

One Month Home-based trial of Neurostimulator TENS-EMS with supplies QTY 1: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) TENS.

Decision rationale: According to the MTUS guidelines, the TENS unit is not recommended as a primary treatment modality. A one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for conditions such as, neuropathic pain, phantom limb pain, complex regional pain syndrome (CRPS), spasticity or multiple sclerosis. In this case, there is no documentation of a functional restoration program. In addition, there is no documentation of conservative management with

physical therapy. Medical necessity for the requested item has not been established. The requested one-month home-based trial of Neurostimulator TENS-EMS with supplies is not medically necessary.

Occupational Medicine Eval and treat QTY 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Occupational Medicine Practice Guidelines, second edition, Chapter 7, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Medicine.

Decision rationale: According to the ODG, physical medicine encompasses interventions that are within the scope of various practitioners (including Physical Therapy, Occupational Therapy (OT), Chiropractic, and MD/DO). In this case, there is no documentation of the specific modalities needed in occupational therapy for treatment of the patient's chronic pain condition. Medical necessity for the requested occupational medicine evaluation and treatments has not been established. The requested services are not medically necessary.

Sleep Study QTY 1: 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) (web) 4/29/11, polysomnography and the US National Library of Medicine and National Institutes of Health, Sleep Apnea Risk Factors.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Polysomnography.

Decision rationale: A polysomnogram measures bodily functions during sleep, including brain waves, heart rate, nasal and oral breathing, sleep position, and levels of oxygen saturation. Polysomnography is recommended after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. It is not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. Home portable monitor testing may be an option. It is administered by a sleep specialist, a physician who is Board eligible or certified by the American Board of Sleep Medicine, or a pulmonologist or neurologist whose practice comprises at least 25% of sleep medicine. Sleep disorder claims must be supported by formal studies in a sleep laboratory. However, home portable monitor testing is increasingly being used to diagnose patients with obstructive sleep apnea (OSA) and to initiate them on continuous positive airway pressure (CPAP) treatment. The latest evidence indicates that functional outcome and treatment adherence in patients evaluated according to a home testing algorithm is not clinically inferior to that in patients receiving standard in-laboratory polysomnography. Polysomnography/sleep studies are recommended for the combination of indications listed below: (1) Excessive daytime

somnolence; (2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); (3) Morning headache (other causes have been ruled out); (4) Intellectual deterioration (sudden, without suspicion of organic dementia); (5) Personality change (not secondary to medication, cerebral mass or known psychiatric problems); (6) Sleep-related breathing disorder or periodic limb movement disorder is suspected; (7) Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended. (8) Unattended (unsupervised) home sleep studies for adult patients are appropriate with a home sleep study device with a minimum of 4 recording channels (including oxygen saturation, respiratory movement, airflow, and EKG or heart rate). In this case, there is no recent documentation indicating the patient's current sleep disturbance and sleep history including hours of sleep, sleep hygiene, nocturnal awakenings, and daytime sleepiness. Therefore, medical necessity for this service has not been established. The requested service is not medically necessary.

Psyche Treatment QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cognitive Behavioral Therapy (CBT).

MAXIMUS guideline: Decision based on MTUS Stress-Related Conditions 2004, Section(s): Treatment.

Decision rationale: The CA MTUS recommends psychological treatment for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and post-traumatic stress disorder). The guidelines recommend an initial trial of 3-4 psychotherapy visits over 2 weeks, and with evidence of objective functional improvement, a total of 6-10 visits over 5-6 weeks. In this case, there is no specific indication for ongoing psychiatric treatment. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

X-ray cervical spine QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The CA MTUS ACOEM Guidelines indicate that if neck symptoms persist beyond four to six weeks, further evaluation may be indicated. The injured worker has been complaining of neck pain since his injury on 05/09/2015. The criteria for ordering imaging

studies are: emergence of a red flag; physiologic evidence of tissue injury or trauma or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; and clarification of the anatomy before an invasive procedure. The guidelines also indicate that "cervical radiographs are most appropriate for patients with acute trauma associated with midline vertebral tenderness, head injury, drug or alcohol intoxication, or neurologic compromise." There was no documentation of evidence of any of these criteria. There is also no documentation of a failure of conservative management. Medical necessity for the requested x-ray has not been established. The requested x-ray is not medically necessary.

X-ray thoracic spine QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The CA MTUS guidelines do not address thoracic spine x-rays. The ODG does not recommend x-rays of in absence of red flags for serious spinal pathology, even if the pain persists for greater than 6 weeks. Thoracic spine x-rays are recommended for pain, tenderness, severe trauma, a neurological deficit, sudden onset of myelopathy, myelopathy of infectious disease patient and post-surgical fusion for evaluation. Documentation does not include previous treatments for back pain or failed conservative treatment. Therefore, the request for one x-ray of thoracic spine is not medically necessary.

X-ray lumbar spine QTY 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: Lumbar spine radiography should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. According to the American College of Radiology, "It is now clear from previous studies that uncomplicated acute low back pain is a benign, self-limited condition that does not warrant any imaging studies." Indications for plain x-rays include, lumbar spine trauma with pain and tenderness, neurologic deficit, or chance of a fracture. In addition, x-rays are indicated for uncomplicated low back pain, steroids, osteoporosis, age over 70, suspicion of cancer or infection; myelopathy and post-surgery to evaluate the status of a fusion. Medical necessity for the requested x-ray has not been established. The requested x-ray is not medically necessary.

X-ray left shoulder QTY 1: 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) Treatment Index, 9th Edition (web), Treatment; Integrated Treatment/Disability Duration Guidelines, Shoulder (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

Decision rationale: According to ACOEM Guidelines, x-rays of the shoulder are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when there is evidence on history and/or physical exam, which raises suspicion of a serious shoulder condition. Cases of shoulder impingement are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen around the glenohumeral or AC joint. In this case, the physical exam is not legible and does not appear to indicate specific evidence of instability. Medical necessity for the requested x-ray of the left shoulder has not been established. The requested item is not medically necessary.

X-ray right shoulder QTY 1: 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) Treatment Index, 9th Edition (web), Treatment; Integrated Treatment/Disability Duration Guidelines, Shoulder (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

Decision rationale: According to ACOEM Guidelines, x-rays of the shoulder are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when there is evidence on history and/or physical exam, which raises suspicion of a serious shoulder condition. Cases of shoulder impingement are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen around the glenohumeral or AC joint. In this case, the physical exam is not legible and does not appear to indicate specific evidence of instability. Medical necessity for the requested x-ray of the right shoulder has not been established. The requested item is not medically necessary.

X-ray left hand/wrist QTY 1: 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) Treatment Index, 5th Edition (web), 2007, Arm & hand X-rays.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Radiography of the hand/wrist.

Decision rationale: According to the ODG, x-rays of the hand/wrist are recommended for most patients with known or suspected trauma of the hand, wrist, or both. The conventional radiographic survey provides adequate diagnostic information and guidance to the surgeon. However, in one large study, wrist fractures, especially those of the distal radius and scaphoid, accounted for more delayed diagnoses than any other traumatized region in patients with initial normal emergency room radiographs. Thus, when initial radiographs are equivocal, or in the presence of certain clinical or radiographic findings, further imaging is appropriate. In this case, there is no documentation of symptoms or acute injury involving the left hand/wrist. Medical necessity for the requested x-rays has not been established. The requested x-rays are not medically necessary.

X-ray right hand/wrist QTY 1: 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) Treatment Index, 5th Edition (web), 2007, Arm & hand X-rays.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Radiography of the hand/wrist.

Decision rationale: According to the ODG, x-rays of the hand/wrist are recommended for most patients with known or suspected trauma of the hand, wrist, or both. The conventional radiographic survey provides adequate diagnostic information and guidance to the surgeon. However, in one large study, wrist fractures, especially those of the distal radius and scaphoid, accounted for more delayed diagnoses than any other traumatized region in patients with initial normal emergency room radiographs. Thus, when initial radiographs are equivocal, or in the presence of certain clinical or radiographic findings, further imaging is appropriate. In this case, there is no documentation of symptoms or acute injury involving the right hand/wrist. Medical necessity for the requested x-rays has not been established. The requested x-rays are not medically necessary.

Support for lumbar spine QTY 1: 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), Treatment Index, 5th Edition, 2007, Low Back-supports.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar supports.

Decision rationale: According to the ODG, lumbar supports are 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). According to MTUS/ACOEM guidelines, lumbar support braces have not been shown to have

lasting benefit beyond the acute phase of symptom relief. In this case, this patient has had chronic low back pain complaints, and a lumbar support brace is not warranted. Medical necessity for the requested lumbar support brace has not been supported or established. The requested item is not medically necessary.

Supports for wrist QTY 2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute, Official Disability Guidelines Treatment in Workers Compensation, 10th Edition, Treatment Index, Carpal Tunnel Syndrome (updated 5/7/13).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Wrist Splinting.

Decision rationale: The ODG recommends splinting of wrist in neutral position at night and day, as needed, as an option in conservative treatment. Use of daytime wrist splints has positive, but limited evidence. Splinting after surgery has negative evidence. When treating with a splint, there is scientific evidence to support the efficacy of neutral wrist splints in carpal tunnel syndrome (CTS), and it may include full-time splint wear instructions as needed, versus night-only. CTS may be treated initially with a splint and medications before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits). In this case, there is no documentation indicating that the patient has carpal tunnel syndrome. There is no specific indication for wrist supports. Medical necessity for the requested items has not been established. The requested item is not medically necessary.