

<b>Case Number:</b>	CM15-0063151		
<b>Date Assigned:</b>	04/17/2015	<b>Date of Injury:</b>	12/02/2014
<b>Decision Date:</b>	07/15/2015	<b>UR Denial Date:</b>	04/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2015

### 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: Pennsylvania

Certification(s)/Specialty: Internal 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 43 year old female who sustained an industrial injury on 12/02/2014. She reported pain to the hand from repetitive work activities with driving a bus. The injured worker was diagnosed as having sprain/strain of the right hand, probable carpal tunnel syndrome of the right upper extremity, cervical sprain/strain, cervical subluxation, cervicobrachial syndrome, lumbar sprain/strain, and lumbar subluxation. Medical history includes high cholesterol and diabetes. Treatment to date has included right hand x-ray, use of hot pack, use of cold pack, use of a smart glove with thumb metal, one session of physical therapy, and medications. On 12/2/14, x-rays of the right hand were normal. The injured worker was provided with a hot/cold therapy pack. The documentation indicates that the injured worker underwent electrodiagnostic studies of the right upper extremity with findings of carpal tunnel syndrome; the report and date of testing were not submitted. The injured worker underwent orthopedic consultation on 1/5/15. The injured worker was provided with a wrist splint and electrodiagnostic testing was recommended. At a visit on 2/9/15, the injured worker reported neck pain, pain in the right upper extremity and into all the digits of the right hand as well as two fingers of the left hand, leg cramps, toe numbness, and back pain. Examination showed grip loss in the right upper extremity, normal upper extremity deep tendon reflexes, hypoesthesia in the C5-6 and C6-7 dermatomes bilaterally, positive Tinel's sign and Phalen's sign on the right, and positive cervical compression. The injured worker was working modified duties with restrictions. In a progress note dated 02/19/2015 the injured worker had complaints of pinching and tingling to the bilateral hands, stiffness and tension to the neck, aching pain to the upper and lower back, heavy

weakness and aching pain to the right arm and right shoulder, numbness to the fingers of the left hand, and spasms to the bilateral legs and to the bilateral big toes. Examination of the right wrist showed no bruising, swelling, atrophy, or lesion. The treating physician requested x-rays of the right wrist, electromyogram of the bilateral upper extremities, physiotherapy and chiropractic therapy twice a week for three weeks, use of a back brace, use of a transcutaneous electrical nerve stimulation unit, and an orthopedic consultation. The documentation provided did not indicate the specific reasons for these requested treatments. The treating physician also requested use of a hot/cold unit to be used to decrease the injured worker's pain and decrease the need for oral medication. Work status was changed to temporary total disability. On 3/24/15, Utilization Review non-certified requests for the items currently under Independent Medical Review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**X-ray of the right wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

**Decision rationale:** The ACOEM states that for most patients with hand and wrist problems, special studies are not needed until after a 4-6 week period of conservative care and observation. Radiographs may be obtained for acute injury with suspicion of fracture. Imaging studies may be warranted if the history and examination suggest specific disorders, such as infection. This injured worker has right upper extremity pain. X-rays of the right hand were normal in December 2014. There was no documentation of re-injury. Recent examination of the right wrist was unremarkable. Due to lack of specific indication, the request for x-ray of the right wrist is not medically necessary.

**EMG of upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): ch 8 p. 168-171, 182, ch 11 p. 268-269, 272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter: EMG, nerve conduction studies.

**Decision rationale:** This injured worker has neck and upper extremity pain. The ACOEM recommends EMG (electromyogram) to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural steroid injection. There was no discussion of plan for surgery or epidural steroid injection. The ODG notes that EMG is moderately sensitive in relation to cervical radiculopathy. While cervical electrodiagnostic studies are not necessary to

demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. There are no reports from the prescribing physician which adequately describe neurologic findings that necessitate electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. There is no specific neurological information showing the need for electrodiagnostic testing. This injured worker has had prior electrodiagnostic testing that was not discussed by the treating physician. No repeat testing would be indicated absent a significant clinical change as well as a discussion of those test results. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

**Mechanical traction:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): ch 8 p. 181, ch 12 p. 300, 308.

**Decision rationale:** This injured worker has neck and low back pain. The body part to be treated with traction was not specified in the request. Traction for the low back is specifically not recommended by the MTUS. Traction has not been proved effective for lasting relief in treating low back pain. Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended. Cervical traction is specifically not recommended by the MTUS, as noted in the ACOEM neck and upper back chapter summary of recommendations for evaluating and managing neck and upper back complaints. As traction is not recommended by the guidelines, the request for mechanical traction is not medically necessary.

**CMT extraspinal and electro stimulation 2x3:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, 181, Chronic Pain Treatment Guidelines manual therapy and manipulation Page(s): p. 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back: manipulation.

**Decision rationale:** This injured worker has right upper extremity, neck and back pain and right carpal tunnel syndrome. The documentation indicates that chiropractic therapy was requested for the right upper extremity, neck, and back. Per the MTUS for Chronic Pain, the purpose of manual medicine is functional improvement, progression in a therapeutic exercise program, and return to productive activities (including work). Per the MTUS for Chronic Pain, a trial of 6 visits of manual therapy and manipulation may be provided over 2 weeks, with any further manual therapy contingent upon functional improvement. Per the MTUS, chiropractic manipulation is not recommended for the "Ankle & Foot, Carpal tunnel syndrome, Forearm, Wrist, & Hand, Knee." The MTUS for chronic pain is silent on use of manipulation of the neck. The ACOEM states that cervical manipulation is a treatment option for neck pain or cervicogenic headache when used in the context of functional restoration rather than for pain alone, but that there is insufficient evidence to support manipulation for radiculopathy. Physical manipulation for neck pain is an option for treatment early in care only. The ODG notes that cervical manipulation is recommended as an option. As the physician has documented that one of the areas to be treated with chiropractic was the right upper extremity, and as the guidelines do not recommend chiropractic manipulation for the forearm, wrist, and carpal tunnel syndrome, the request for CMT extraspinal and electro stimulation 2x3 is not medically necessary.

**Hot/ Cold Unit for right wrist:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264-265, 271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) forearm, wrist, & hand chapter: heat therapy.

**Decision rationale:** The ACOEM and ODG recommend at-home applications of cold packs for the first few days of acute complaints and thereafter applications of heat therapy. There is no recommendation for any specific device in order to accomplish this. There was lack of documentation to indicate the frequency of use of the device, and no end point to use was specified. In addition, there was no documentation as to why at-home application of hot or cold packs would be insufficient. The documentation also indicates that the injured worker was provided with a hot/cold therapy pack in December 2014. For these reasons, the request for hot/cold unit is not medically necessary.

**Multi Stim unit for 5 months rental:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** Electrotherapy represents the therapeutic use of electricity and is a modality that can be used in the treatment of chronic pain. Transcutaneous electrical nerve stimulation

(TENS) devices are the most commonly used; other devices are distinguished from TENS based on their electrical specifications. The Multi-stim unit includes TENS, interferential, and neuromuscular stimulation. The MTUS specifies that TENS is not recommended as a primary modality but a one-month home based TENS trial may be considered if used as an adjunct to a program of evidence based functional restoration for certain conditions, including neuropathic pain, complex regional pain syndrome, phantom limb pain, spasticity in spinal cord injury, multiple sclerosis, and acute post-operative pain. A treatment plan with the specific short and long-term goals of treatment with the TENS unit should be submitted. Neuromuscular stimulation is not recommended outside of the post-stroke rehabilitative context and there is no evidence to support its use in chronic pain. There was no documentation of diagnosis of stroke for this injured worker. Per the MTUS, interferential current stimulation is not recommended as an isolated intervention. If certain criteria are met, a one-month trial may be appropriate to permit the physician and physical medicine provider to determine effects and benefits. Criteria include pain which is ineffectively controlled by medications, history of substance abuse, pain from postoperative conditions that limit the ability to perform exercise programs, or lack of response to conservative measures. The treating physician has not provided a treatment plan for use of TENS as outlined by the MTUS. None of the criteria for use of interferential current stimulation were present for this injured worker. In addition, one of the modalities in this unit, neuromuscular stimulation, is not recommended for chronic pain. As such, the request for Multi Stim unit for 5 months rental is not medically necessary.

**Physical therapy 2x3 for right wrist:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: physical medicine treatment.

**Decision rationale:** Physical medicine is recommended by the MTUS with a focus on active treatment modalities to restore flexibility, strength, endurance, function, and range of motion, and to alleviate discomfort. The ODG states that patients should be formally assessed after a six visit clinical trial to evaluate whether physical therapy has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. Both the MTUS and ODG note that the maximum number of sessions for unspecified myalgia and myositis is 9-10 visits over 8 weeks, and 8-10 visits over 4 weeks for neuralgia, neuritis, and radiculitis. The records do not contain a sufficient prescription from the treating physician, which must contain diagnosis, duration, frequency, and treatment modalities, at a minimum. Reliance on passive care is not recommended. The physical medication prescription is not sufficiently specific, and does not adequately focus on functional improvement. No functional goals were discussed. Physical medicine for chronic pain should be focused on progressive exercise and self-care, with identification of functional deficits and goals, and minimal or no use of passive modalities. A non-specific prescription for "physical therapy" in cases of chronic pain is not sufficient. Due to insufficiently specific prescription, the request for Physical therapy 2x3 for right wrist is not medically necessary.

**Consultation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

**Decision rationale:** This injured worker has right upper extremity pain and diagnosis of carpal tunnel syndrome. The documentation from the physician indicates that this request is for an orthopedic consultation. The ACOEM states that 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 worksite modifications, and have clear clinical and special study evidence of a lesion that has been shown to benefit from surgical consultation. Surgical considerations depend on the confirmed diagnosis of the presenting hand or wrist complaint. There was no documentation of red flag conditions or lack of response to conservative therapy. This injured worker has already undergone orthopedic consultation in January of 2015, at which time she was provided with a wrist splint; there was no discussion of use of the splint or outcome of treatment. There was no discussion of consideration of surgery for carpal tunnel syndrome, and the report of the prior electrodiagnostic testing which was noted to have shown carpal tunnel syndrome was not submitted. As such, the request for consultation is not medically necessary.