

Case Number:	CM13-0023031		
Date Assigned:	10/16/2013	Date of Injury:	05/31/2013
Decision Date:	05/28/2014	UR Denial Date:	08/23/2013
Priority:	Standard	Application Received:	09/11/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is an employee of [REDACTED] and has submitted a claim for carpal tunnel syndrome and lateral epicondylitis of the elbow associated with an industrial injury date of May 31, 2013. Utilization review from August 23, 2013 denied the requests for Manipulation, infrared and electrical stimulation for the thoracic spine and right elbow due to no evidence of proven effectiveness for the elbows and exceeding recommended number of visits for chiropractic visits; right hand paraffin was denied due to no documentation concerning arthritic hands. Treatment to date has included medications. Medical records from 2013 were reviewed showing the patient complaining of thoracic spine, right-handed/wrist, and right elbow pain. The pain is aggravated by prolonged activity. Physical exam demonstrated a decrease in the right L5 and S1 deep tendon reflexes. There was noted spasm and tenderness over the thoracic spine area. There was tenderness over the right medial and lateral epicondyles. Cozen's test was positive on the right as well as reverse Cozen's test. Neurological exam for the bilateral upper extremities revealed a decrease in the bilateral median nerve peripheral distribution at the wrists. There was spasm and tenderness on the right anterior wrist, right posterior extensor tendons, and right thenar eminence. Tinel's was positive on the right. Phalen's was positive bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

Manipulation, infrared and electrical stimulation for the thoracic spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Pain, Restoration of Function Chapter, page 114

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 57, 58-60, 114.

Decision rationale: As stated on pages 58-60 of the CA MTUS Chronic Pain Medical Treatment Guidelines, manipulation is recommended for chronic pain is caused by musculoskeletal conditions. Manipulation for the low back is recommended primarily as a trial of 6 visits and with evidence of objective functional improvement, a total of up to 18 visits. Page 114 of the California MTUS Chronic Pain Medical Treatment Guidelines state that transcutaneous electrotherapy has a variety of units which have different recommendations based on guidelines. The California MTUS does not address infrared therapy. Page 57 of the California MTUS Chronic Pain Medical Treatment Guidelines state that low level laser therapy, therapy that uses near infrared lasers, is not recommended. In this case, the patient has significant back complaints with muscular spasms. However, physical exam demonstrated neurological deficits; the patient's problem has not been isolated to just a musculoskeletal problem. In addition, the exact number of sessions was not specified in the request. Regarding infrared therapy, there is no discussion concerning the need for variance from the guidelines. Regarding electrical stimulation, the request is not specific to a single unit. Given the above-mentioned reasons, the request for Manipulation, infrared and electrical stimulation for the thoracic spine is not medically necessary.

Manipulation, infrared and electrical muscle stimulation for the right elbow: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 265.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 57-58, 114.

Decision rationale: As stated on page 58 of the California MTUS Chronic Pain Medical Treatment Guidelines, manipulation is not recommended for the forearm, wrist, and hand. Page 114 of the California MTUS Chronic Pain Medical Treatment Guidelines state that transcutaneous electrotherapy has a variety of units which have different recommendations based on guidelines. The California MTUS does not address infrared therapy. Page 57 of the California MTUS Chronic Pain Medical Treatment Guidelines state that low level laser therapy, therapy that uses near infrared lasers, is not recommended. In this case, the patient has right elbow complaints. Regarding the electrical muscle stimulation, there is no specific unit requested. Regarding the manipulation and infrared for the right elbow, there is no discussion concerning the need for variance from the guidelines as these are not recommended. Therefore, the request for Manipulation, infrared and electrical muscle stimulation for the right elbow is not medically necessary.

Manipulation of the right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: As stated on page 58 of the California MTUS Chronic Pain Medical Treatment Guidelines, manipulation is not recommended for the forearm, wrist, and hand. In this case, the patient has significant right wrist complaints. However, there is no discussion concerning the need for variance from the guidelines. Therefore, the request for manipulation of the right wrist is not medically necessary.

Right hand paraffin: 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), Forearm, Wrist, & Hand, Paraffin Wax Bath

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, Paraffin Wax Bath

Decision rationale: The CA MTUS does not address paraffin wax baths specifically. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Forearm, Wrist, & Hand, paraffin wax bath was used instead. The Official Disability Guidelines state that paraffin wax baths are recommended as an option for arthritic hands if used as an adjunct to a program of evidence based conservative care such as exercise. In this case, the patient complains of carpal tunnel syndrome. There is no evidence in the documentation concerning arthritic hands. Therefore, the request for right hand paraffin is not medically necessary.