

Case Number:	CM14-0180213		
Date Assigned:	11/04/2014	Date of Injury:	02/21/2013
Decision Date:	12/09/2014	UR Denial Date:	10/25/2014
Priority:	Standard	Application Received:	10/30/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 61-year-old female with a 2/21/13 date of injury. At the time (10/13/14) of request for authorization for 12 Physical Therapy sessions, One interferential unit, 1 Internal medicine consultation within [REDACTED] between 10/13/2014 and 12/22/2014, 1 X-ray of the cervical spine between 10/13/2014 and 10/13/2014, 1 X-ray of the right wrist between 10/13/2014 and 10/13/2014, and 1 X-ray of the left wrist between 10/13/2014 and 10/13/2014, there is documentation of subjective (neck and wrists pain) and objective (tenderness over the paraspinal musculature and trapezius muscles with spasms, positive axial compression test, negative Tinel's test, negative Phalen's sign, positive Finkelstein's test on the left and positive grind test) findings, current diagnoses (cervical/trapezial musculoligamentous sprain/strain, bilateral wrist flexor/extensor tendinitis with left de Quervain's tenosynovitis, and left first carpometacarpal joint osteoarthritis), and treatment to date (medications, acupuncture, and previous physical therapy treatments). Medical report identifies that the request for internal medicine consultation is for determination of Arising out of Employment/Course of Employment of increased diabetes. Regarding physical therapy, the number of previous physical therapy sessions cannot be determined. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of physical therapy provided to date. Regarding interferential unit, there is no documentation that the interferential stimulator unit will be used in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Regarding internal medicine consultation, there is no documentation that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the

examinee's fitness for return to work. Regarding X-ray of right wrist, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which x-ray of the wrist/hand is indicated.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Physical therapy sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Physical therapy (PT), Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with diagnosis of sprains and strains of neck not to exceed 10 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of cervical/trapezial musculoligamentous sprain/strain, bilateral wrist flexor/extensor tendinitis with left de Quervain's tenosynovitis, and left first carpometacarpal joint osteoarthritis. In addition, there is documentation of previous physical therapy treatments. Furthermore, given documentation of subjective (neck pain) and objective (tenderness over the paraspinal musculature and trapezius muscles with spasms and positive axial compression test) findings, there is documentation of functional deficits and functional goals. However, there is no documentation of the number of previous physical therapy sessions and, if the number of treatments have exceeded guidelines, remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of physical therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for 12 Physical therapy sessions is not medically necessary.

One interferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ICS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that interferential current stimulation is not recommended as an isolated intervention and that there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Within the medical information available for review, there is documentation of diagnoses of cervical/trapezial musculoligamentous sprain/strain, bilateral wrist flexor/extensor tendinitis with left de Quervain's tenosynovitis, and left first carpometacarpal joint osteoarthritis. However, there is no documentation that the interferential stimulator unit will be used in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Therefore, based on guidelines and a review of the evidence, the request for 1 interferential unit is not medically necessary.

1 Internal medicine consultation within [REDACTED] between 10/13/2014 and 12/22/2014: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 387-388.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and consultations, page(s) 127

Decision rationale: MTUS reference to ACOEM guidelines identifies that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work, as criteria necessary to support the medical necessity to support the medical necessity of consultation. Within the medical information available for review, there is documentation of diagnoses of cervical/trapezial musculoligamentous sprain/strain, bilateral wrist flexor/extensor tendinitis with left de Quervain's tenosynovitis, and left first carpometacarpal joint osteoarthritis. However, given documentation that the request for internal medicine consultation is for determination of Arising Out of Employment/Course Of Employment of increased diabetes, there is no documentation that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. Therefore, based on guidelines and a review of the evidence, the request for 1 Internal medicine consultation within [REDACTED] between 10/13/2014 and 12/22/2014 is not medically necessary.

1 X-ray of the cervical spine between 10/13/2014 and 10/13/2014: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of emergence of red flag, physiological evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, or clarification of anatomy prior to an invasive procedure, as criteria necessary to support the medical necessity of cervical spine x-rays. Within the medical information available for review, there is documentation of diagnoses of cervical/trapezial musculoligamentous sprain/strain, bilateral wrist flexor/extensor tendinitis with left de Quervain's tenosynovitis, and left first carpometacarpal joint osteoarthritis. In addition, given documentation of subjective (neck pain) and objective (positive axial compression test) findings, there is documentation of physiologic evidence of tissue insult or neurologic dysfunction. Therefore, based on guidelines and a review of the evidence, the request for 1 X-ray of the cervical spine between 10/13/2014 and 10/13/2014 is medically necessary.

1 X-ray of the right wrist between 10/13/2014 and 10/13/2014: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 267-268.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand, Radiography

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of a four-to-six week period of conservative care and observation, provided red flags conditions are ruled out, as criteria necessary to support the medical necessity of hand/wrist x-ray. ODG identifies documentation of a condition/diagnosis (with supportive subjective/objective findings) for which x-ray of the wrist/hand is indicated (such as: Acute hand or wrist trauma, wrist trauma, first exam; Acute hand or wrist trauma, suspect acute scaphoid fracture, first exam, plus cast and repeat radiographs in 10-14 days; Acute hand or wrist trauma, suspect distal radioulnar joint subluxation; Acute hand or wrist trauma, suspect hook of the hamate fracture; Acute hand or wrist trauma, suspect metacarpal fracture or dislocation; Acute hand or wrist trauma, suspect phalangeal fracture or dislocation; Acute hand or wrist trauma, suspect thumb fracture or dislocation; Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury); Chronic wrist pain, first study obtained in patient with chronic wrist pain with or without prior injury, no specific area of pain specified), as criteria necessary to support the medical necessity of wrist/hand x-ray. Within the medical information available for review, there is documentation of diagnoses of cervical/trapezial musculoligamentous sprain/strain, bilateral wrist flexor/extensor tendinitis with left de Quervain's tenosynovitis, and left first carpometacarpal joint osteoarthritis. In addition, there is documentation of four-to-six week period of conservative care. However, given documentation of objective (positive Finkelstein's

test on the LEFT and positive grind test on the LEFT) findings, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which x-ray of the right wrist/hand is indicated (Acute hand or wrist trauma, wrist trauma, first exam; Acute hand or wrist trauma, suspect acute scaphoid fracture, first exam, plus cast and repeat radiographs in 10-14 days; Acute hand or wrist trauma, suspect distal radioulnar joint subluxation; Acute hand or wrist trauma, suspect hook of the hamate fracture; Acute hand or wrist trauma, suspect metacarpal fracture or dislocation; Acute hand or wrist trauma, suspect phalangeal fracture or dislocation; Acute hand or wrist trauma, suspect thumb fracture or dislocation; Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury); Chronic wrist pain, first study obtained in patient with chronic wrist pain with or without prior injury, no specific area of pain specified). Therefore, based on guidelines and a review of the evidence, the request for 1 X-ray of the right wrist between 10/13/2014 and 10/13/2014 is not medically necessary.

1 X-ray of the left wrist between 10/13/2014 and 10/13/2014: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 257-258.

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

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of a four-to-six week period of conservative care and observation, provided red flags conditions are ruled out, as criteria necessary to support the medical necessity of hand/wrist x-ray. ODG identifies documentation of a condition/diagnosis (with supportive subjective/objective findings) for which x-ray of the wrist/hand is indicated (such as: Acute hand or wrist trauma, wrist trauma, first exam; Acute hand or wrist trauma, suspect acute scaphoid fracture, first exam, plus cast and repeat radiographs in 10-14 days; Acute hand or wrist trauma, suspect distal radioulnar joint subluxation; Acute hand or wrist trauma, suspect hook of the hamate fracture; Acute hand or wrist trauma, suspect metacarpal fracture or dislocation; Acute hand or wrist trauma, suspect phalangeal fracture or dislocation; Acute hand or wrist trauma, suspect thumb fracture or dislocation; Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury); Chronic wrist pain, first study obtained in patient with chronic wrist pain with or without prior injury, no specific area of pain specified), as criteria necessary to support the medical necessity of wrist/hand x-ray. Within the medical information available for review, there is documentation of diagnoses of cervical/trapezial musculoligamentous sprain/strain, bilateral wrist flexor/extensor tendinitis with left de Quervain's tenosynovitis, and left first carpometacarpal joint osteoarthritis. In addition, there is documentation of four-to-six week period of conservative care. Furthermore, given documentation of objective (positive Finkelstein's test on the LEFT and positive grind test on the LEFT) findings, there is documentation of a condition/diagnosis (with supportive subjective/objective findings) for which x-ray of the wrist/hand is indicated (chronic wrist pain). Therefore, based on guidelines and a review of the evidence, the request for 1 X-ray of the left wrist between 10/13/2014 and 10/13/2014 is medically necessary.

