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| <b>Case Number:</b>   | CM14-0211070 |                              |            |
| <b>Date Assigned:</b> | 12/23/2014   | <b>Date of Injury:</b>       | 06/16/2004 |
| <b>Decision Date:</b> | 02/27/2015   | <b>UR Denial Date:</b>       | 11/24/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/16/2014 |

### 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. 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: Physical Medicine & Rehabn, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a patient with a date of injury of June 16, 2004. A utilization review determination dated November 24, 2014 recommends noncertification of ergonomic equipment. Noncertification was recommended due to a lack of clear rationale provided for the request, lack of information regarding the type of equipment requested, and limited information regarding an ergonomic evaluation. A progress report dated December 6, 2014 identifies subjective complaints of increased bilateral wrist pain with intermittent numbness and tingling at night. Objective examination findings reveal negative Tinel's and tender flexion/extension. Diagnoses include cervical spine sprain/strain, bilateral shoulder sprain, bilateral elbow medial epicondylitis, and (illegible). The treatment plan recommends ergonomic equipment, physical therapy, wrist (illegible), and follow-up.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ergonomic equipment:** 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), Carpal Tunnel Syndrome Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 6.

**Decision rationale:** Regarding the request for Ergonomic equipment, Occupational Medicine Practice Guidelines state that engineering controls, including ergonomic workstation evaluation and modification, and job redesign to accommodate a reasonable proportion of the workforce may well be the most cost effective measure in the long run. Within the documentation available for review, it is unclear exactly what ergonomic problems are present at the patient's worksite. The requesting physician has not identified what type of biomechanical issues he feels is contributing to the patient's ongoing symptoms and what type of "ergonomic equipment" might be necessary. In the absence of clarity regarding those issues, the currently requested Ergonomic equipment is not medically necessary.