

<b>Case Number:</b>	CM15-0068616		
<b>Date Assigned:</b>	04/16/2015	<b>Date of Injury:</b>	08/15/2003
<b>Decision Date:</b>	05/15/2015	<b>UR Denial Date:</b>	03/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/10/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 50 year old female, who sustained an industrial injury on August 15, 2003. She reported neck pain radiating to bilateral upper extremities, low back pain radiating to bilateral lower extremities, chest wall pain, anxiety, and giving way of the right leg with associated falls. The injured worker was diagnosed as having bilateral moderate to severe carpal tunnel syndrome, cervical disc degeneration, cervical radiculopathy, headaches, anxiety, rule out rotator cuff tear and non-steroidal anti-inflammatory intolerance. Treatment to date has included diagnostic studies, pain injections, conservative care, medications and work restrictions. Currently, the injured worker complains of continued neck pain radiating to bilateral upper extremities, low back pain radiating to bilateral lower extremities, chest wall pain, anxiety, and giving way of the right leg with associated falls. The injured worker reported an industrial injury in 2003, resulting in the above noted pain. She was treated conservatively without complete resolution of the pain. Evaluation on February 6, 2015, revealed continued pain as noted. It was noted she was waiting for cervical, shoulder and carpal tunnel surgeries. Chiropractic care, wrist braces and a cervical pillow were requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Wrist Braces (purchase): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist and Hand Chapter, Splints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

**Decision rationale:** The ACOEM chapter on wrist complaints and braces states: When treating with a splint in CTS, scientific evidence supports the efficacy of neutral wrist splints. Splinting should be used at night, and may be used during the day, depending upon activity. The patient does not have the diagnosis of bilateral carpal tunnel syndrome. The ODG also does not recommend wrist braces for chronic wrist pain. Therefore wrists braces/splints are not medically indicated and the request is not medically necessary.

**Cervical Pillow (purchase):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck Chapter, Cervical Pillow.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, neck pillow.

**Decision rationale:** The ACOEM and California MTUS do not specifically address the requested service. The ODG does recommend neck pillows in patients with chronic neck pain in conjunction with neck exercise. The clinical documentation provided for review meets these criteria and therefore the request is medically necessary.

**Chiropractic Therapy (8 sessions, 2 times a week for 4 weeks for the lumbar and cervical spine):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines manual manipulation Page(s): 58-59.

**Decision rationale:** The California chronic pain medical guidelines section on manual manipulation states: Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine 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. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care Trial of 6 visits over 2 weeks, with evidence

of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care is not medically necessary. Recurrences/flare-ups Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines; a. Time to produce effect: 4 to 6 treatments. Manual manipulation is recommended form of treatment for chronic pain. However the requested amount of therapy sessions is in excess of the recommendations per the California MTUS. The California MTUS states there should be not more than 6 visits over 2 weeks and documented evidence of functional improvement before continuation of therapy. The request is for 8 sessions. This does not meet criteria guidelines and thus is not medically necessary.