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| <b>Case Number:</b>   | CM15-0071007 |                              |            |
| <b>Date Assigned:</b> | 04/27/2015   | <b>Date of Injury:</b>       | 08/21/2014 |
| <b>Decision Date:</b> | 07/24/2015   | <b>UR Denial Date:</b>       | 03/25/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/14/2015 |

### 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 28-year-old female who has reported back and upper extremity symptoms after pushing and pulling on 08/21/2014. The diagnoses have included lumbar radiculopathy; lumbar sprain/strain; right wrist sprain/strain; carpal tunnel syndrome, and right wrist tenosynovitis. Treatment to date has included physical therapy, medications, and chiropractic care. The injured worker was initially seen by medical doctors and treated with medications, 13 sessions of physical therapy, a wrist brace, and light duty. She was improved and returned to full duty on 11/7/14. Lumbar radiographs on 10/10/14 were normal. She was then seen by chiropractors and was referred for various tests and treatments, including such things as a Sudoscan and a sleep study. Treatment reports from the treating chiropractors reflect ongoing multifocal pain, no discussion of the results of any treatment, no specific indications for the requested treatment items, no signs of specific and significant pathology, and temporarily totally disabled work status. One of the referrals was to a medical doctor, the same request now referred for Independent Medical Review. That medical doctor submitted a Request for Authorization on 4/21/15 for compound topical medications, a urine drug screen, and multiple oral medications (no opioids). The PR2 of that date did not provide a medical basis for prescribing any of the medications or tests. The same items were requested on 1/27/15 and 3/24/15, and the PR2s likewise did not provide discussion of the basis for the treatment items. These same treatments were initiated on 12/8/14 by a different MD, again without discussion of the basis for treatment in the medical report. The records contain reports from physical therapy during December 2014- January 2015, approximately 8 visits for passive modalities and unspecified exercises. There is no discussion of the specific results or benefits. Per the chiropractic PR2 of 3/19/15, there was ongoing neck pain, low back pain, right wrist pain, and right hand pain with paresthesias. Grip strength on the right was 2 kg. Range of motion of the painful areas was limited and painful. No neurological deficits were present. A Phalen's test

was positive (no details given). The treatment plan included chiropractic, MRIs, wrist x-ray, electrodiagnostic testing, MD referral for medication, functional capacity examination (FCE), and temporarily totally disabled work status. The associated Request for Authorization included additional treatment items, as listed in this Independent Medical Review. The Request for Authorization stated that the MD referral was for pain medication and urine screen to r/o meds toxicity. The content of the requested physical therapy was not stated. Specific indications for imaging were not discussed. The durable medical equipment (DME) were for pain relief and increasing range of motion. On 3/24/15 Utilization Review non-certified the multiple requests referred for this Independent Medical Review, citing the Official Disability Guidelines and the MTUS, and stating the requests did not meet the recommendations of the guidelines.

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

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

#### **MRI of the lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), MRI, Lumbar Spine.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 291-296, 303, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, MRI.

**Decision rationale:** The treating physician has not described the clinical evidence of significant pathology discussed in the MTUS, such as "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination". No 'red flag' conditions are identified. The treating physician has not provided an adequate clinical evaluation, as outlined in the MTUS ACOEM Guidelines Pages 291-296. Per the Official Disability Guidelines citation above, imaging for low back pain is not beneficial in the absence of specific signs of serious pathology. Repeat imaging should be based on the presence of new symptoms and signs. The lumbar radiographs were normal. The treating physician has not provided specific indications for performing an MRI. An MRI of the lumbar spine is not indicated in light of the paucity of clinical findings suggesting any serious pathology; increased or ongoing pain, with or without radiation, is not in itself an indication for MRI. An MRI of the lumbar spine is not medically necessary based on lack of sufficient indications per the MTUS and the Official Disability Guidelines.

#### **MRI of the right wrist: 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).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 254-258, 268-269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, hand, wrist chapter; MRI ½.

**Decision rationale:** The ACOEM Guidelines pages 254-258 list the criteria for examining the hand and wrist. The necessary components of the examination are not present. The specific historical details of any wrist symptoms are not described sufficiently. Per Page 268-269 of the

ACOEM Guidelines, special studies are not needed until after a 4-week period of conservative care. Common tests are listed, with indications. Specific care for the wrist was not described adequately. The treating physician has not provided sufficient indications for any imaging test, including an MRI. The Official Disability Guidelines list the following indications for an MRI: Acute hand or wrist trauma, suspect acute distal radius fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required. Acute hand or wrist trauma, suspect acute scaphoid fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required. Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury). Chronic wrist pain, plain films normal, suspect soft tissue tumor. Chronic wrist pain, plain film normal or equivocal, suspect Kienbock's disease. None of these conditions were described by the treating physician. The wrist MRI is not medically necessary based on the lack of sufficient indications and the cited guidelines.

**X-ray of the right wrist:** 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).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 254-258, 268-269.

**Decision rationale:** The ACOEM Guidelines pages 254-258 list the criteria for examining the hand and wrist. The necessary components of the examination are not present. The specific historical details of any wrist symptoms are not described sufficiently. Per Page 268-269 of the ACOEM Guidelines, special studies are not needed until after a 4-week period of conservative care. Common tests are listed, with indications. Specific care for the wrist was not described adequately. The treating physician has not provided sufficient indications for any imaging test, including radiographs. The wrist radiographs are not medically necessary based on the lack of sufficient indications and the cited guidelines.

**Physical therapy at two times a week for four weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, functional improvement, Physical Medicine Page(s): 9, 98-99.

**Decision rationale:** The treating physician has not provided an adequate prescription, which must contain diagnosis, duration, frequency, and treatment modalities, at minimum. Per the MTUS, Chronic Pain section, functional improvement is the goal rather than the elimination of pain. The maximum recommended quantity of Physical Medicine visits is 10, with progression to home exercise. The treating physician has not provided specific indications for the current physical therapy prescription. It is not clear what is intended to be accomplished with this physical therapy, given that it will not cure the pain and there are no other goals of therapy. This injured worker has already completed a course of Physical Medicine which exceeds the quantity of visits recommended in the MTUS. She completed 13 visits with the prior primary treating physician and 8 visits since she started treatment with the chiropractor. No medical

reports identify specific functional deficits, or functional expectations for further Physical Medicine. The Physical Medicine prescription is not sufficiently specific, and does not adequately focus on functional improvement. There is no evidence of functional improvement from the physical therapy to date, as function was not discussed and the work status was temporarily totally disabled, indicating profound disability. Total disability work status implies a complete lack of functional improvement. Given the completely non-specific prescription for physical therapy in this case, it is presumed that the therapy will use or even rely on passive modalities. Note that the MTUS recommends against therapeutic ultrasound and passive modalities for treating chronic pain. Additional Physical Medicine is not medically necessary based on the MTUS, lack of sufficient emphasis on functional improvement, and the failure of Physical Medicine to date to result in functional improvement as defined in the MTUS.

**Follow-up with MD for medical and urine drug screen:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 6, page 115.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines approach to medications for chronic pain Page(s): 7-8.

**Decision rationale:** The treating chiropractor has not provided any specific indications for this referral other than the apparent generic need for medications and urine testing for toxicity. The MTUS, per the citation above, discusses the indications for medications to treat chronic pain and the variables that should be considered. There is no discussion of an approach based on functional improvement in any of the recent treating physician reports. The medication prescribing that has occurred in this case has been far outside of the recommendations of the MTUS and the FDA, including chronic muscle relaxants and topical compounds which are not indicated. It is not clear what sort of urine testing is intended for monitoring toxicity, as usual clinical urine testing in clinical practice is not performed for this purpose. Urine drug screens are tests performed for a different purpose. The treating chiropractor has not made an adequate case for this referral in light of the specific patient factors and the MTUS recommendations. The treatment already provided by the medical doctor does not comply with the MTUS recommendations and is not medically necessary. The referral is therefore not medically necessary.

**Lumbar spine hot pack:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 48, 299-300, 308. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM Guidelines, Updated Chronic Pain Section, page 166, 168; heat and cold therapies.

**Decision rationale:** The MTUS for Chronic Pain does not provide direction for the use of heat or cold to treat chronic pain. The ACOEM Guidelines pages 299-300 recommend application of heat or cold for low back pain. At-home applications of heat or cold are as effective as those performed by therapists. Page 308 recommends home application of heat or cold. There is no recommendation for any specific device in order to accomplish this. Heat and cold can be applied to the skin using simple home materials, e.g. ice and hot water, without any formal

medical device or equipment. Per Page 48 of the Guidelines, heat or cold may be used for two weeks or less. This patient's condition is long past the two-week duration. The updated ACOEM Guidelines for Chronic Pain are also cited. There may be some indication for heat or cold therapy, but the recommendation is for home application of non-proprietary, low-tech, therapy in the context of functional restoration. There is no evidence of any current functional restoration program, and the temporarily totally disabled work status is evidence of a treatment plan not focused on functional restoration. The treating physician has not provided any information in support of the specific device prescribed for this patient, and the nature of the requested device was not explained. The heat device prescribed for this injured worker is not medically necessary based on the MTUS, other guidelines, and lack of a sufficient treatment plan.

**Lumbar spine brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention, Chapter 12 Low Back Complaints Page(s): 9, 308. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM Guidelines, Update 4/7/08, Low Back Chapter, page 138, lumbar supports.

**Decision rationale:** The ACOEM Guidelines do not recommend lumbar binders, corsets, or support belts as treatment for low back pain, see page 308. On Page 9 of the Guidelines, "The use of back belts as lumbar support should be avoided because they have been shown to have little or no benefit, thereby providing only a false sense of security. " The updated ACOEM Guidelines likewise do not recommend lumbar braces for treatment of low back pain. The treating physician has not provided any specific evidence to counter these guideline recommendations. The lumbar brace is therefore not medically necessary.

**Right wrist brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264, 266, 272.

**Decision rationale:** Per the MTUS citations above, there may be a role for wrist splinting for conditions such as strains and carpal tunnel syndrome. Prolonged splinting is not recommended. This injured worker has already used a splint, and there is no discussion of the results of using that splint and for what duration the splint was used. The treating physician has stated that the splint is to help increase range of motion, which is counter to the effect of using a brace, which limits range of motion. The MTUS specifically notes that prolonged splinting can lead to weakness and stiffness. Use of a brace this long after the injury, when the condition is chronic and without specific indications for treating specific pathology, is not medically necessary.

**TENS/ EMS:** 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 TENS, chronic pain, Neuromuscular electrical stimulation (NMES devices) Page(s): 114-117, 121.

**Decision rationale:** No physician reports address the specific medical necessity for a transcutaneous electrical nerve stimulation (TENS) unit. The MTUS for Chronic Pain lists the indications for TENS, which are primarily neuropathic pain, a condition not present in this patient. Other recommendations, including specific components of the treatment plan, are listed in the MTUS. The necessary kind of treatment plan is not present, including a focus on functional restoration with a specific trial of TENS alone. Neuromuscular stimulation, per the MTUS, is not recommended for chronic pain. Given the lack of clear indications in this injured worker for TENS, the MTUS proscription against electronic muscle stimulation (EMS), and the lack of any clinical trial or treatment plan per the MTUS, a TENS/EMS unit is not medically necessary.