

Case Number:	CM15-0094648		
Date Assigned:	05/20/2015	Date of Injury:	03/19/2014
Decision Date:	07/08/2015	UR Denial Date:	04/23/2015
Priority:	Standard	Application Received:	05/15/2015

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: Florida

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 37 year old female, who sustained an industrial injury on 3/19/2014, while employed as a dresser. She reported that a coworker leaned, with all her weight, into her right wrist. The injured worker was diagnosed as having right wrist/hand sprain/strain, rule out internal derangement. Treatment to date has included unspecified computerized tomography, unspecified x-rays, unspecified magnetic resonance imaging, cortisone injection, bracing, and medications. Electromyogram and nerve conduction studies (12/23/2014) were consistent with right mild carpal tunnel syndrome and right mild ulnar neuropathy, localized across the elbow. On 2/23/2015, the injured worker complained of constant and burning right wrist and hand pain, rated 7/10. She also complained of weakness, numbness, and tingling in her hand and fingers. Exam noted tenderness to palpation at the carpal bones and on the thenar eminence. Range of motion in the right wrist was decreased. Sensation was slightly decreased over the C5, C6, C7, C8, and T1 dermatomes in the right upper extremity. Motor strength was 4/5 in all represented muscle groups in the right upper extremity. Deep tendon reflexes and vascular pulses were 2+ and symmetrical in the upper extremities. Current medication regime was not noted. The treatment plan included x-rays and magnetic resonance imaging of the right wrist/hand, transcutaneous electrical nerve stimulation unit with supplies, hot/cold unit, physical therapy (3x6), acupuncture (3x6), and chiropractic (3x6) for the right wrist/hand. Also recommended were Terocin patches and a Functional Capacity Evaluation. Her work status was total temporary disability. On 3/30/2015, her complaints were unchanged, and pain was rated 6/10. Physical exam was unchanged. It was noted that she was to continue with the course of physical

therapy, acupuncture, and chiropractic (3x6). The number of completed sessions was note noted. Progress reports from current or previous therapies were not submitted. Her work status remained total temporary disability.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 3x week x 6 weeks for the Right Wrist/Hand: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic therapy Page(s): 95.

Decision rationale: Chiropractic therapy is being requested. MTUS guidelines specifically state that chiropractic therapy for the hand and wrist is "not recommended." No compelling indication has been presented to disagree with MTUS guidelines. Likewise, this request is not considered medically necessary.

TENS Unit with Supplies (purchase): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain medical treatment guidelines, TENS unit, 114-117.

Decision rationale: California MTUS guidelines recommend the following regarding criteria for TENS unit use: 1. Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. 2. There is evidence that other appropriate pain modalities have been tried (including medication) and failed. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. 3. Other ongoing pain treatment should also be documented during the trial period including medication usage. 4. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. 5. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. This patient's case does not meet the recommended criteria since no treatment plan (that includes short and long term goals) was submitted. There is also no documentation that other treatment modalities have been tried and failed. No documentation of a 1 month trial period with a TENS unit, and the associated objective functional benefits has been submitted. Likewise, this request for a TENS unit with supplies is not medically necessary.

Cold Unit (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 (ODG) Treatment Index, 11th Edition (web), 2014, Forearm, Wrist & Hand, Continuous-flow cryotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back pain/neck pain complaints Page(s): 257.

Decision rationale: MTUS guidelines state regarding the application of hot and cold treatment modalities, "At-home local applications of cold packs during first few days of acute complaints; thereafter, applications of heat packs." Also, there is no literature documentation of superiority over typical readily available hot and cold applications (such as those that can be applied at home.) Likewise, this request for purchase of a cold unit is not considered medically necessary.

Hot Unit (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 (ODG) Treatment Index, 11th Edition (web), 2014, Forearm, Wrist & Hand, Heat Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back pain/neck pain complaints Page(s): 257.

Decision rationale: MTUS guidelines state regarding the application of hot and cold treatment modalities, "At-home local applications of cold packs during first few days of acute complaints; thereafter, applications of heat packs." Also, there is no literature documentation of superiority over typical readily available hot and cold applications (such as those that can be applied at home.) Likewise, this request for purchase of a cold unit is not considered medically necessary.

Physical Therapy 3x week x 6 weeks for the Right Wrist/Hand: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 11th Edition (web), 2014, Forearm, Wrist & Hand, Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): page(s) 99 of 127.

Decision rationale: In accordance with MTUS guidelines, the physical medicine recommendations state, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." Guidelines also state, "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." This patient has previously had 18 sessions of physical therapy, but now his physician is requesting an additional 18 sessions. The exact results (functional benefit derived) from the last set of physical therapy sessions is not

documented. The guidelines recommend fading of treatment frequency with transition to a home exercise program, which this request for a new physical therapy plan does not demonstrate. Likewise, this request is not medically necessary.