

Case Number:	CM13-0072699		
Date Assigned:	01/08/2014	Date of Injury:	06/23/2012
Decision Date:	06/09/2014	UR Denial Date:	12/24/2013
Priority:	Standard	Application Received:	12/31/2013

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 Physical Medicine & Rehabilitation 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:

The patient has filed a claim for headache associated with an industrial injury of June 23, 2012. Thus far, the patient has been treated with depirizine, dicopanol, fanatrex, synapryn, tabradol, topical creams, lumbar epidural steroid injection. The patient has had left thumb surgery on June 29, 2012. Review of progress notes reports frequent sharp headaches. Patient also has pain of the neck, bilateral shoulders, left elbow, left wrist, left thumb, left ribs, low back radiating to bilateral lower extremities, left inguinal region, right thigh, and bilateral knees. Findings include tenderness and decreased cervical range of motion of the cervical spine, bilateral shoulders, left elbow, left wrist, left thumb, bilateral knees. There are findings suggestive of cervical radiculopathy, left shoulder rotator cuff pathology, lumbar radiculopathy, and ACL and meniscal tear of the knees. Electrodiagnostic studies of the upper extremities dated August 2 and October 2012 were normal. For the lower extremities, it showed abnormalities for bilateral peroneal nerves. Lumbar MRI performed on July 07, 2012 showed disc extrusion at L4-5 with tear with minimal bilateral lateral recess narrowing which flattens the L5 nerve roots and right neuroforaminal narrowing, and questionable spondylosis at the right L5-S1 level. Left shoulder MRI from September 2012 showed subacromial/subdeltoid bursitis and posterior superior labral tear. Left knee MRI showed tears of the medial and lateral meniscus, and x-ray from October 2012 showed findings consistent with prior MCL injury. Left thumb x-ray showed a healing fracture.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 NCV/EMG OF RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 178, 212, 33, 261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238.

Decision rationale: CA MTUS criteria for EMG/NCV of the upper extremity include documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. In this case, symptoms and objective findings are not consistent with cervical radiculopathy or nerve entrapment, and there is no documentation that the patient has exhausted all conservative management strategies. Patient has been only on above mentioned medications and activity restrictions since February 2013. Therefore, the request for NCV/EMG of right upper extremity is not medically necessary and appropriate.

NCV/EMG OF LEFT UPPER EXTRMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 178, 212, 33, 261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238.

Decision rationale: CA MTUS criteria for EMG/NCV of the upper extremity include documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. In this case, symptoms and objective findings are not consistent with cervical radiculopathy or nerve entrapment, and there is no documentation that the patient has exhausted all conservative management strategies. Patient has been only on abovementioned medications and activity restrictions since February 2013. Therefore, the request for NCV/EMG of left upper extremity is not medically necessary and appropriate.

1 NCV/EMG OF RIGHT LOWER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic).

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

Decision rationale: As noted on page 303 of the MTUS ACOEM Guidelines, EMGs are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, ODG states that EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. Furthermore, NCVs are not recommended when symptoms are presumed to be on the basis of radiculopathy. In this case, although the patient presents with lower extremity findings suggestive of underlying radiculopathy, there is no documentation of use and failure of conservative management strategies in this patient. There is no clear indication as to the necessity of this procedure at this time. Therefore, the request for NCV/EMG of the right lower extremity is not medically necessary and appropriate.

1 NCV/EMG OF THE LEFT LOWER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic).

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

Decision rationale: As noted on page 303 of the MTUS ACOEM Guidelines, EMGs are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, ODG states that EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. Furthermore, NCVs are not recommended when symptoms are presumed to be on the basis of radiculopathy. In this case, although the patient presents with lower extremity findings suggestive of underlying radiculopathy, there is no documentation of use and failure of conservative management strategies in this patient. There is no clear indication as to the necessity of this procedure at this time. Therefore, the request for NCV/EMG of the left lower extremity is not medically necessary and appropriate.

1 CONSULTATION WITH ORTHOPEDIC SURGEON REGARDING LEFT SHOULDER, LEFT THUMB AND LEFT KNEE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 196, 254. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM) 2ND EDITION (2004), INDEPENDENT MEDICAL EXAMINATIONS AND CONSULTATIONS, 127, 156; Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), page 196 and Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), page 254.

Decision rationale: As stated on pages 127 and 156 in the CA MTUS ACOEM Independent Medical Examinations and Consultations chapter, occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Referral for surgical consultation for the shoulder is indicated with red flag conditions, activity limitation for more than four months with existence of a surgical lesion, and failure to increase ROM and strength of the musculature around the shoulder even after exercise programs. Regarding the thumb, referral may be necessary with an acute injury to the metacarpophalangeal joint of the thumb accompanied by tenderness on the ulnar side of the joint and laxity when that side of the joint is stressed. Regarding the knee, surgical consultation may be indicated for patients who have activity limitation for more than one month, and failure of exercise programs to increase ROM and strength of the musculature around the knee. In this case, there is no documentation of abovementioned conditions with regards to the patient's left knee, left thumb, and left shoulder. Also, there is no documentation of exercise programs or physical treatment modalities aimed at strengthening the knee or shoulder. Therefore, the request for consultation with orthopedic surgeon regarding left shoulder, left thumb, and left knee was not medically necessary and appropriate.

1 TENS UNIT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

Decision rationale: As stated in pages 114-116 in the California MTUS chronic pain medical treatment guidelines, a one-month home-based TENS trial may be considered as a noninvasive conservative option with a rental being preferred over a purchase during this trial. Criteria include chronic intractable pain (at least 3 months duration), evidence of failure of other appropriate pain modalities, and treatment plan including specific short- and long-term goals of treatment. In this case, there is no documentation of use and failure of other conservative management strategies to address the patient's multiple pain problems. There is also no description of the treatment plan with regards to TENS use. Therefore, the request for TENS unit is not medically necessary and appropriate.

1 HOT AND COLD THERAPY UNIT: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Continuous-Flow Cryotherapy.

Decision rationale: CA MTUS does not apply. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In this case, there is no documentation that patient will be undergoing surgery. There is no clear indication for use of hot and cold therapy unit. Therefore, the request for hot and cold therapy unit was not medically necessary per the guideline recommendations of ODG.