

Case Number:	CM14-0006818		
Date Assigned:	02/07/2014	Date of Injury:	05/02/2013
Decision Date:	06/09/2014	UR Denial Date:	01/02/2014
Priority:	Standard	Application Received:	01/15/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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 injured worker is a 32-year-old female who sustained an injury to her right elbow on 05/02/13 when working as a dispatcher; she reached across her desk and felt a pop in her right elbow. The patient developed pain and swelling after this as was seen in the emergency room, then by her primary care physician. Plain radiographs of the right elbow were negative. The injured worker was prescribed nonsteroidal anti-inflammatory drugs, Medrol Dosepak, sling and taken off work. The patient was referred to an orthopedic specialist. The patient stated she also gets numbness in her right forearm/hand. her request for cool care therapy unit times one unit is not medically necessary. A office note dated 01/02/14 reported that the request for right elbow: open exploration and sub-muscular transposition of the right ulnar nerve was certified and the request for postoperative physical therapy x 12 visits was modified to 10. The requests for coolcare cold therapy unit x 1 unit, surgi-stim unit x 90 days, pre-op medical clearance and repeat EMG/NCV were denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

COOLCARE COLD THERAPY UNIT X 1 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), 11th Edition Web 2013.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow Chapter, Cold Packs.

Decision rationale: The previous request was denied on the basis that the request is not considered consistent with ODG guidelines. The ODG recommends at-home applications of cold packs during first few days; thereafter applications of either heat or cold packs to suit patient. Given the clinical documentation submitted for review, the request for Coolcare Cold Therapy unit x 1 unit is not medically necessary.

SURGI-STIM UNIT X 90 DAYS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, POST OPERATIVE PAIN (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION) Page(s): 114-121.

Decision rationale: The previous request was denied on the basis that there was no clear indication to provide this as a primary source of postoperative analgesic for this particular procedure. The CAMTUS states that Transcutaneous electrical nerve stimulation (TENS) appears to be most effective for mild to moderate thoracotomy pain. It has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. The proposed necessity of the unit should be documented upon request. Rental would be preferred over purchase during this 30-day period. Given the clinical documentation submitted for review, the request for Surgi-Stim unit x 90 days is not medically necessary.

PRE-OPERATIVE MEDICAL CLEARANCE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Harrison's Textbook of Medicine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow Chapter, Office Visits.

Decision rationale: The previous request was denied on the basis that a complete evaluation had already been carried out. The need for a separate medical clearance is not apparent in this injured worker who has no significant health issues provided. Given the clinical documentation submitted for review, the request for Pre-Operative Medical Clearance is not medically necessary.

REPEAT ELECTROMYOGRAPHY (EMG) OF THE RIGHT UPPER EXTREMITY:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: The previous request was denied on the basis that the procedures had already been performed on 07/01/13 and that the studies were markedly positive and that there was no indication for repeat studies. There was no additional information provided that would support the need for repeat electrodiagnostic studies. Given the clinical documentation submitted for review, the request for repeat Electromyography (EMG) of the right upper is not medically necessary.

REPEAT NERVE CONDUCTION VELOCITY STUDY OF THE RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: The previous request was denied on the basis that the procedures had already been performed on 07/01/13 and that the studies were markedly positive and that there was no indication for repeat studies. There was no additional information provided that would support the need for repeat electrodiagnostic studies. Given the clinical documentation submitted for review, medical necessity of the request for repeat Nerve Conduction Velocity study of the right upper extremity is not medically necessary.

POST-OPERATIVE PHYSICAL THERAPY, 12 VISITS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 10, 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines FOREARM, WRIST, & HAND Page(s): 22. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES FOREARM, WRIST, & HAND, , 22.

Decision rationale: The previous request was denied on the basis that guidelines recommend an initial course of half the allowed visits for post-surgical treatment. The CAMTUS recommends up to 20 visits over 10 weeks for the diagnosed injury; therefore, the request was modified for 10 visits. Given the clinical documentation submitted for review, the request for Post-Operative Physical Therapy, is not medically necessary.