

Case Number:	CM14-0011349		
Date Assigned:	02/21/2014	Date of Injury:	10/16/2013
Decision Date:	07/24/2014	UR Denial Date:	01/20/2014
Priority:	Standard	Application Received:	01/28/2014

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 Physical Medicine and Rehabilitation 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 23-year-old female who sustained an injury to her right wrist on October 16, 2013. The mechanism of injury was not documented. Plain radiographs of the right wrist dated November 04, 2013 revealed no obvious acute fracture or destructive changes; evidence of minimal hypertrophic changes at the base of the first metacarpal bone. Physical examination revealed limited and painful range of motion of the right wrist/elbow. The clinical note dated December 26, 2013 reported that the patient presented with panic attacks, right wrist pain, stress, anxiety and insomnia. The injured worker is been treated with medications, splinting and activity modification. She was diagnosed with carpal tunnel syndrome, forearm tendinitis, DQTS, rule out triangular fibrocartilage complex (TFCC) tear, stress, anxiety, insomnia, panic attacks, shortness of breath and undiagnosed chest pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

VOLTAGE ACTUATED SENSORY NERVE CONDUCTION TO CERVICAL SPINE AND UPPER EXTREMITIES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Neck and Upper Back Chapters.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back chapter, Current perception threshold (CPT) testing.

Decision rationale: The request for voltage actuated sensory nerve conduction to cervical spine and upper extremities is not medically necessary. The Official Disability Guidelines state that the use of this modality is not recommended. There are no clinical studies demonstrating that quantitative tests of sensation improve the management and clinical outcomes of patients over standard qualitative methods of sensory testing. The use of any type of sensory nerve conduction threshold (sNCT) device, including a current output type device used to perform current perception threshold (CPT), pain perception threshold (PPT), or pain tolerance threshold (PTT) testing or voltage input type device used for voltage-nerve conduction threshold (v-NCT) testing, to diagnose sensory neuropathies or radiculopathies is not reasonable and necessary. Given the clinical documentation submitted for review, medical necessity of the request for voltage actuated sensory nerve conduction to cervical spine and upper extremities has not been established. Therefore, the request is not medically necessary.

ACUPUNCTURE 2X6: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture (two times per week for six weeks) is not medically necessary. The Acupuncture Medical Treatment Guidelines state that acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm; however, it was unclear how many previous visits the injured worker has completed and the injured worker's response to previous treatment. There was no information provided that indicates that the injured worker is actively participating in a home exercise program. Given the clinical documentation submitted for review, medical necessity of the request for acupuncture (two times per week for six weeks) has not been established. Therefore, the request is not medically necessary.

FUNCTIONAL CAPACITY EVALUATION: 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 Behavioral interventions Page(s): 23.

Decision rationale: The request for functional capacity evaluation is not medically necessary. The previous request was denied on the basis that there was no documentation that would indicate case management is hampered by complex issues to include prior unsuccessful return-

to-work attempts, conflicting medical reporting on precautions and/or fitness for modified job, injuries that required detailed exploration of the workers abilities, timing is appropriate and additional/secondary conditions have been clarified. There was no additional significant objective clinical information that would support reversing the previous adverse determination. Given the clinical documentation submitted for review, medical necessity of the request for functional capacity evaluation has not been established. Therefore, the request is not medically necessary.

PHYSIOTHERAPY 1X6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter.

Decision rationale: The request for physiotherapy once per week for six weeks is not medically necessary. The previous request was denied on the basis that there was no specific documentation of objective functional deficits and injured worker has completed today or the injured worker's response to any previous conservative treatment. Given the clinical documentation submitted for review, medical necessity of the request for physiotherapy one times a week for six weeks has not been established. Therefore, the request is not medically necessary.

PSYCHOLOGICAL EVALUATION AND TREATMENT BASED ON EVALUATION: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23.

Decision rationale: The request for psychological evaluation and treatment based on evaluation is not medically necessary. The previous request was denied on the basis that there was no documentation that would indicate case management is hampered by complex issues to include prior unsuccessful return-to-work attempts, conflicting medical reporting on precautions and/or fitness for modified job, injuries that required detailed exploration of the workers abilities, timing is appropriate and additional/secondary conditions have been clarified. There was no additional significant objective clinical information that would support reversing the previous adverse determination. Given the clinical documentation submitted for review, medical necessity of the request for psychological evaluation and treatment based on evaluation has not been established. Therefore, the request is not medically necessary.

NEURO DIAGNOSTIC MEDICAL/LEGAL EVALUATION REPORT/VSNCT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Neck and Upper Back Chapters.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm , wrist and hand chapter, Office visits.

Decision rationale: The request for neuro diagnostic medical/legal evaluation report/VsNCT is not medically necessary. The Official Disability Guidelines state that the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment; however, there was significant objective clinical information provided that would indicate a need for an office visit at this time. Given the clinical documentation submitted for review, medical necessity of the request for neuro diagnostic medical/legal evaluation report/VsNCT has not been established. Therefore, the request is not medically necessary.

MRI OF RIGHT WRIST: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm , wrist and hand chapter , Magnetic resonance imaging (MRI).

Decision rationale: The request for MRI of the right wrist is not medically necessary. There were no focal neurological deficits on physical examination. There was no mention that a surgical intervention is anticipated. There was no indication of decreased motor strength, increased reflexes sensory deficits. There was no report of a new acute injury or exacerbation of previous symptoms. There was no additional 'red flags' identified. Given the clinical documentation submitted for review, medical necessity of the request for MRI of the right wrist has not been established. Therefore, the request is not medically necessary.

MRI OF RIGHT ELBOW: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209.

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, MRI's.

Decision rationale: The request for MRI of the right elbow is not medically necessary. There were no focal neurological deficits on physical examination. There was no mention that a surgical intervention is anticipated. There was no indication of decreased motor strength, increased reflexes sensory deficits. There was no report of a new acute injury or exacerbation of

previous symptoms. There was no additional 'red flags' identified. Given the clinical documentation submitted for review, medical necessity of the request for MRI of the right elbow has not been established. Therefore, the request is not medically necessary.

AN ELECTROMYOGRAM (EMG) OF THE UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper back chapter, Electromyography (EMG).

Decision rationale: The request for an EMG of the upper extremities is not medically necessary. The Official Disability Guidelines state that while cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality or some problem other than a cervical radiculopathy, but these studies can result in unnecessary over treatment. Given the clinical documentation submitted for review, medical necessity of the request for an EMG of the upper extremities has not been established. Therefore, the request is not medically necessary.

NERVE CONDUCTION VELOCITIES (NCV) OF THE UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back chapter, Nerve conduction studies (NCS).

Decision rationale: The request for an NCV of the upper extremities is not medically necessary. The Official Disability Guidelines states that an NCV is not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by electromyogram (EMG) and obvious clinical signs. However, it is recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. Given the clinical documentation submitted for review, medical necessity of the request for NCV of the upper extremities has not been established. Therefore, the request is not medically necessary.

LOCALIZED INTENSE NEUROSTIMULATION THERAPY (LINT): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: The request for localized intense neurostimulation therapy (LINT) is not medically necessary. The Chronic Pain Medical Treatment Guidelines state that LINT is not recommended. NMES is used primarily as part of a rehabilitation program following a stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. Given the clinical documentation submitted for review, medical necessity of the request for LINT has not been established. Therefore, the request is not medically necessary.

AN INTERFERENTIAL (IF) UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 11.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-16.

Decision rationale: The request for an IF unit is not medically necessary. The Chronic Pain Medical Treatment Guidelines states that while TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters, which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. Given the clinical documentation submitted for review, medical necessity of the request for an IF unit has not been established. Therefore, the request is not medically necessary.