

Case Number:	CM14-0116489		
Date Assigned:	08/04/2014	Date of Injury:	07/17/2013
Decision Date:	09/17/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	07/24/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 50-year-old male who reported a continuous injury from 07/17/2012 to 07/17/2013. The mechanism of injury is unknown. His diagnoses included neck sprain and strain; carpal tunnel syndrome; brachial neuritis or radiculitis, NOS; thoracic/lumbosacral neuritis/radiculitis unspecified; unspecified neuralgia, neuritis, and radiculitis; sprain and strain unspecified site of shoulder and upper arm; thoracic sprain and strain; lumbar sprain and strain. Past treatments were noted to include medications, acupuncture, pain management, diagnostic testing, and urine drug screen. Diagnostic studies included EMG/NCV. His surgical history was not provided. The progress notes are handwritten and hard to decipher. On 06/02/2014, the injured worker was then seen for upper extremity pain. The pain rates were as follows: the cervical spine was 7/10, thoracic spine was 7/10, lumbar spine was 4/10, bilateral shoulders were 4/10, bilateral wrists were 7/10, and bilateral hands were 7/10. There was tenderness to the upper extremities bilaterally. The patient denies tenderness of the lower extremities. There was a positive Kemp's test bilaterally, positive straight leg raise bilaterally, and decreased range of motion. Medications were noted to include tramadol ER 150 mg take 1 capsule at bedtime as needed for pain/sleep. The request is for bilateral EMG, NCV bilateral, TENS unit, and hot/cold machine. The rationale was not provided. The request for authorization was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG Bilateral: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The request for EMG bilateral is not medically necessary. The injured worker has multiple levels of pain of the upper extremity. The California MTUS/ACOEM Guidelines state that electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. An EMG to clarify nerve root dysfunction in cases of suspected disc herniation preoperatively before epidural injection is recommended. EMG for diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent is not recommended. There are lacks of documentation of motor or sensory deficits to suggest any neurologic process. There is lack of documentation of any other neurological finding on exam to question other process like peripheral neuropathy, etc. There is lack of body part to be tested. As such, the request is not medically necessary.

NCV Bilateral: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: NCV bilateral is not medically necessary. The California MTUS/ACOEM Guidelines state that electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. There are no motor or sensory deficits documented to suggest any neurologic process. There is a lack of documentation of exam to question other processes like peroneal neuropathy. There is lack of extremities to be tested. As such, the request is not medically necessary.

TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, (transcutaneous electrical nerve stimulation) Page(s): 114-116.

Decision rationale: The request for a TENS unit is not medically necessary. The injured worker has a history of multiple upper extremity pain. The injured worker has a history of pain in the upper extremities. The California MTUS Guidelines recommend a TENS unit as an adjunct to a program of evidence based functional restoration for chronic neuropathic pain. Additionally a treatment plan including the specific short-term and long-term goals of treatment with the TENS

unit should be submitted. Although this worker did participate in a 30-day trial of a TENS unit, the clinical record submitted for review failed to provide documentation of objective functional benefit that was received and an objective decrease in pain that was a benefit of the TENS unit nor on what part of the body the unit was utilized. Also, the request as submitted failed to indicate the quantity of TENS unit and supplies being requested. There was no specific treatment plan included. Additionally, there was no quantified documentation of the effectiveness of his medication regimen in pain relief. As such, the request is not medically necessary.

Hot/Cold Machine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

Decision rationale: The request for hot/cold machine is not medically necessary. The injured worker has a history of pain in the upper extremities. The California MTUS/ACOEM Guidelines recognize an at-home local applications of cold or heat in first few days of acute complaint; thereafter, applications of heat or cold. Since the injured worker's symptoms are no longer acute, the guidelines do not support the need for this modality. As such, the request is not medically necessary.