MAXIMUS Federal Services

Case Number:	CM14-0033173		
Date Assigned:	06/20/2014	Date of Injury:	11/12/2013
Decision Date:	07/29/2014	UR Denial Date:	03/11/2014
Priority:	Standard	Application Received:	03/17/2014

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 Anesthesiology, has a subspecialty in Pain Medicine 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 injured worker is a 36 year old male who sustained an injury to his left wrist on 11/12/13 after sustaining a burn to his left hand. The injured worker continued to complain of left hand pain radiating to the forearm and fingers with associated numbness and tingling. Treatment to date included three functional restoration visits, three acupuncture visits and medications. Physical examination noted tenderness to palpation of the epigastrium, decreased grip strength bilaterally; tenderness to palpation of the left wrist and thenar imminence; decreased range of motion to muscle strength of left wrist; Tinel's and Phalen's signs positive for carpal tunnel testing of the left wrist. The injured worker was diagnosed with clinical carpal tunnel syndrome and gastritis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continue With Functional Restoration 2X 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs Page(s): 30-33.

Decision rationale: The request for continuation with functional restoration program two times a week times six weeks is not medically necessary. Previous request was denied on the basis that the proposed number of visits, in addition to the visits already provided would exceed guidelines. Therefore, a partial modified certification was made for functional restoration program times six visits, as the guidelines recommend up to nine visits. There was no additional information provided that would indicate the response to initial regimen of functional restoration program. Given this, the request for continuation with functional restoration program two times a week times six weeks is not indicated as medically necessary.

MRI Of Left Wrist and MRI Of Left Hand: 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), Forearm/Wrist/Hand Chapter, Indications for imaging-- MRI.

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, MRI's (magnetic resonance imaging).

Decision rationale: The request for MRI of the left wrist and left hand is not medically necessary. The previous request was denied on the basis that given the associated therapeutic request, there was no documentation of a diagnosis/condition for which an MRI is indicated (significant persistent pain unresponsive to a trial of four weeks of conservative management). There was no report of a new acute injury or exacerbation of previous symptoms. There was no mention that surgical intervention was anticipated. There were no additional significant 'red flags' identified. Mechanism of injury was described as burn injury. There was no indication of ligamentous or injury or bony abnormalities. Given this, the request for MRI of the left wrist and hand is not indicated as medically necessary.

EMG (Electromyography) Of Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 238. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter.

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 electrodiagnostic study EMG/NCV of the bilateral upper extremities is not medically necessary. Previous request was denied on the basis that there was no documentation of failure of conservative treatment and that the etiology of the radicular symptoms is not explained by MRI or other diagnostic studies. Records reflect that the injured worker sustained a left upper extremity injury. There was no report of right upper extremity injury that would warrant studies of the bilateral upper extremities. Given this, medical necessity

of the request for EMG/NCV of the bilateral upper extremities is not indicated as medically necessary.

NCV (Nerve Conduction Velocity) Of Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 238. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter.

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 EMG/NCV of the bilateral upper extremities is not medically necessary. Previous request was denied on the basis that there was no documentation of failure of conservative treatment and that the etiology of the radicular symptoms is not explained by MRI or other diagnostic studies. Records reflect that the injured worker sustained a left upper extremity injury. There was no report of right upper extremity injury that would warrant studies of the bilateral upper extremities. Given this, medical necessity of the request for EMG/NCV of the bilateral upper extremities is not indicated as medically necessary.

ROM (Range Of Motion) & Muscle Strength Testing: 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), Low Back Chapter.

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, Physical/ Occupational therapy.

Decision rationale: The request for range of motion and muscle strength testing is not medically necessary. Previous request was denied on the basis that there was no documentation of a statement indicating why the more widely accepted physical examination methods are insufficient for this patient. Evidence based guidelines do not consistently support for the use of computerized range of motion and muscle testing in the evaluation/management of the cited injuries. After reviewing the clinical documentation submitted for review, there was no additional significant objective clinical information provided that would support reversing the previous adverse determination. Given this, the request for range of motion and muscle strength testing is not medically necessary.

Continue With Acupuncture X 12: 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 continuation with acupuncture times 12 visits is not medically necessary. Previous request was denied on the basis that given the associated request for functional restoration program, there was no clear documentation of the rationale for providing concurrent physical modalities. After reviewing the clinical documentation submitted for review, there was no additional significant objective clinical information provided that would support reversing the previous adverse determination. Given this, the request for continuation of acupuncture x 12 visits is not indicated as medically necessary.

Urinalysis (Collected 2/5/14- Retro Request): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Screen Page(s): 43.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Urine drug testing (UDT).

Decision rationale: The request for urinalysis (collected 02/05/14-retro request) is not medically necessary. The previous request was denied on the basis that there was no documentation of ongoing opioid treatment. After reviewing the clinical documentation submitted for review, there was no additional significant objective clinical information provided that would support reversing the previous adverse determination. Given this, the request for urinalysis (collected 02/05/14-retro request) is not indicated as medically necessary.

Transdermal Compound (Unknown Medications In Compound): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Compounded medicaitions Page(s): 111-113.

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

Decision rationale: The request for transdermal compound (unknown medications in compound) is not medically necessary. The previous request was denied on the basis that current evidence based guidelines do not consistently support compounded medications. Given the nature that the compounded medications were unknown, medical the request for transdermal compound (unknown medications In compound) is not indicated as medically necessary.

Thermacooler System - Hot/ Cold Compression System With Pad Wrap X 8 Weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation PMID: 18214217 [PubMed-indexed MEDLINE].

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Online version, Continuous-flow cryotherapy.

Decision rationale: The request for Thermacooler System - Hot/ Cold Compression System With Pad Wrap X 8 Weeks is not medically necessary. The previous request was denied on the basis that current evidence based guidelines do not consistently support the use of hot/cold therapy contrast systems in the management of the cited injury/condition. There was no information provided that would indicate that this modality could not be replaced by the use of traditional hot/cold packs and ace bandages. Given this, the request for Thermacooler System - Hot/ Cold Compression System With Pad Wrap X 8 Weeks is not indicated as medically necessary.