MAXIMUS Federal Services

Case Number:	CM14-0042506		
Date Assigned:	06/20/2014	Date of Injury:	01/15/2006
Decision Date:	07/22/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	03/13/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician 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 Physician 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 58-year-old female who reported an injury on 01/15/2008. The mechanism of injury was not provided. The clinical note dated 03/03/2014 noted the injured worker presented with upper back and neck pain that radiated to the left upper extremity, weakness, low back, buttock, and lateral hip pain, especially left groin pain, overall knee pain and swelling with weakness. Other therapies included surgery, medication, and physical therapy. Upon examination of the upper back and neck there was tenderness with a positive Spurling's with upper extremity radiculopathy radiating down to the hands, the shoulder abduction maximally to 160 degrees, diminished grip and elbow flexion and extension, motor strength on the left side is 3/5 and the right side is 5/5 with no pain or guarding. There was a positive left straight leg raise. The left knee revealed 2-3+ effusion, swelling, and a lack of 10 degrees of full extension. The diagnoses were left shoulder sprain with tendonitis that is post arthroscopy, cervical sprain with left neck pain, lumbar sprain, left hip sprain, sacroiliac sprain, left knee sprain, status post knee replacement, left heel plantar fasciitis, and reactive anxiety and depression secondary to chronic pain. The provider recommended transportation to and from physical therapy, an electromyography of the upper bilateral extremities, a nerve conduction study, and a hospital bed. The provider recommended a hospital bed due to multiple injuries including back, left hip, neck, and shoulder to optimize positioning and reduce pain medication. The provider recommended continued transportation to and from physical therapy due to increasing left hip, back, neck, and upper extremity condition and she was having to do some driving with a stick shift with a weak left arm, weak left leg, and buttock and back pain. The rationale for the EMG and NCV studies was not provided. The Request for Authorization Form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued transporation to and from physical therapy, orthopedic and infectious disease appointments X 2 months: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines- TWC Knee and Leg Procedure Summary.

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, Transportation (to & from appointments).

Decision rationale: The request for continued transportation to and from physical therapy, orthopedic and infectious disease appointments x2 months is not medically necessary. The Official Disability Guidelines indicate that transportation is recommended for medically necessary transportation to appointments in the same community for injured workers with disability preventing them from self transport. It is recommended by the provider that the injured worker receive additional transportation; however, it is noted that the injured worker is able to drive and there is limited evidence presenting a significant functional deficit involving difficulty with transfers and a medical condition that would warrant transportation services. The current functional status does not demonstrate a medical necessity for transportation. As such, the request is not medically necessary.

Electromyography (EMG) of the bilateral upper extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back Procedure Summary.

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

Decision rationale: The California MTUS/ACOEM Guidelines indicate that electromyography may help identify subtle focal neurologic dysfunction in injured workers with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. An EMG is not needed unless a 3 or 4 week period of conservative care and observation fails to improve symptoms. The injured worker has complaints of radiating symptoms into the left upper extremity and evidence of failed conservative treatment. It was also noted that there is diminished grip strength, decreased motor strength throughout the left upper extremity to 3/5, and a positive Spurling's on the left. Based on this evidence of radiculopathy in a nonspecific distribution, an EMG would be supported on the left upper extremity. However, the documentation submitted for review failed to show evidence of subtle neurological deficits in the right upper extremity. Therefore, electromyography is not supported for the right upper extremity. As such, the request is not medically necessary.

Nerve Conduction Velocity (NCV) Study: 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)- TWC Neck & Upper Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back, Nerve Conduction Studies.

Decision rationale: The request for nerve conduction velocity study is not medically necessary. The California MTUS/ACOEM Guidelines indicate that a nerve conduction velocity may help identify subtle focal neurologic dysfunction in injured workers with neck or arm symptoms, or both, lasting more than 3 or 4 weeks. More specifically, the Official Disability Guidelines further indicate that Nerve Conduction studies are not recommended to demonstrate radiculopathy if radiculopathy is already clearly identified by EMG and obvious clinical signs. The injured worker has complaints of radiating symptoms into the left upper extremity and evidence of failed conservative treatment. It was also noted that there is diminished grip strength, decreased motor strength throughout the left upper extremity to 3/5, and a positive Spurling's on the left. However, the documentation submitted for review failed to show evidence of subtle neurological deficits in the right upper extremity. In addition, the injured worker has not undergone EMG. Therefore, NCV studies are not supported as these tests are recommended only when radiculopathy is not clearly identified by EMG. Further, the request did not indicate whether the nerve conduction study was intended for the upper or lower extremities. As such, the request is not medically necessary.

Continued usage of a hospital bed X 6 months (rental or purchase): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Clinical Policy Bulletins: Hospital Beds and Accessories Policy.

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, Mattress Selection.

Decision rationale: The request for continued usage of a hospital bed x 6 months for rental or purchase is not medically necessary. The Official Disability Guidelines indicate there are no high quality studies to support purchase of any type of specialized mattress or bedding for medical treatment. Mattress selection is objective and depends on personal preference and individual factors. However, pressure ulcers may be treated by special support surfaces designed to redistribute pressure. In the medical documents provided, there is limited evidence of extraneous circumstances that would require body positioning, head elevation due to some disease or special attachment to support the need for continued use of a hospital bed. The

efficacy of use with the hospital bed to optimize positioning and reduce pain medication is not documented. As such, the request is not medically necessary.