

Case Number:	CM14-0086872		
Date Assigned:	07/23/2014	Date of Injury:	06/18/2013
Decision Date:	09/16/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/10/2014

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, has a subspecialty in Pain Management 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:

This is a patient with a date of injury of 6/18/13. A utilization review determination dated 6/4/14 recommends non-certification of IF unit, cold therapy unit, MRIs of the lumbar spine, thoracic spine, elbows, and knees, physical therapy, and a functional capacity evaluation. 3/4/14 medical report identifies pain in the elbows, middle back, lower back, and knees. On exam, there is elbow tenderness with spasm, positive Tinel's at the cubital tunnel, thoracic and lumbar tenderness as spasm, positive tripod test and rotation/extension test, positive SLR right 40 degrees and left 60 degrees, limited range of motion (ROM), 1+ swelling at the knees with tenderness medially and laterally, positive McMurray's, and positive apprehension. ROM is said to be full with pain, but later said to be restricted with pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bio Touch IF unit with supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120 of 127.

Decision rationale: Regarding the request for interferential unit, California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested interferential unit is not medically necessary.

Cold therapy unit purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

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 and Knee Chapters.

Decision rationale: Regarding the request for cold therapy unit purchase, California Medical Treatment Utilization Schedule (MTUS) does not address the issue. Official Disability Guidelines (ODG) does support the use of cold therapy units for up to 7 days following surgery for some body parts, but it is not recommended for nonsurgical treatment. Within the documentation available for review, there is no indication of recent or pending surgery and there is also no provision for modification from purchase to a 7-day rental. In light of the above issues, the currently requested cold therapy unit purchase is not medically necessary.

MRI thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (Lumbar and Thoracic) Chapter, MRIs (magnetic resonance imaging).

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) and American College of Occupational and Environmental Medicine (ACOEM) states that

unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Official Disability Guidelines (ODG) states that magnetic resonance imaging (MRIs) are recommended for uncomplicated low back pain with radiculopathy after at least one month of conservative therapy. Within the documentation available for review, there is no identification of any objective findings that identify specific nerve compromise on the neurologic exam. In the absence of such documentation, the currently requested MRI is not medically necessary.

MRI bilateral Elbows: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 42.

Decision rationale: Regarding the request for Magnetic resonance imaging (MRI) bilateral elbows, California Medical Treatment Utilization Schedule (MTUS) does support its use for conditions such as suspected ulnar collateral ligament tears, but not for suspected epicondylalgia. Within the documentation available for review, there are no symptoms/findings suggestive of a condition for which an MRI would be supported, as only elbow tenderness with spasm and a positive Tinel's at the cubital tunnel are documented, and no clear rationale identifying the medical necessity of advanced imaging has been presented. In light of the above issues, the currently requested MRI bilateral elbows is not medically necessary.

MRI bilateral knees.: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345.

Decision rationale: Regarding the request for magnetic resonance imaging (MRI) bilateral knees, California Medical Treatment Utilization Schedule (MTUS) and American College of Occupational and Environmental Medicine (ACOEM) state that reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. They do support the use of MRI in the evaluation of conditions such as meniscal tears. Within the medical information made available for review, there is documentation of knee pain with 1+ swelling at the knees with tenderness medially and laterally, positive McMurray's, and positive

apprehension. Imaging to rule in/rule out the presence of meniscal tears is appropriate. In light of the above, the currently requested MRI bilateral knees is medically necessary.

Electromyography (EMG) Bilateral Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electrodiagnostic Studies.

Decision rationale: Regarding the request for Electromyography (EMG) bilateral lower extremities, California Medical Treatment Utilization Schedule (MTUS) and American College of Occupational and Environmental Medicine (ACOEM) state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. Within the documentation available for review, there are no symptoms and findings suggestive of focal neurologic dysfunction. In the absence of such documentation, the currently requested EMG bilateral lower extremities is not medically necessary.

Nerve conduction velocity (NCV) Bilateral Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: Regarding the request for nerve conduction velocity (NCV) bilateral lower extremities, California Medical Treatment Utilization Schedule (MTUS) does not specifically address the issue. Official Disability Guidelines (ODG) states that nerve conduction studies are not recommended for back conditions. They go on to state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the documentation available for review, there are no symptoms and findings suggestive of peripheral neuropathy for which an NCV study would be indicated. In the absence of such documentation, the currently requested NCV bilateral lower extremities is not medically necessary.

Physical therapy 2 x 4 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 8.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99 OF 127.

Decision rationale: Regarding the request for physical therapy, California Medical Treatment Utilization Schedule (MTUS) supports up to 10 physical therapy sessions and cites that "patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." Within the documentation available for review, the patient has a longstanding injury, but there is no documentation of specific objective functional improvement with any previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. In light of the above issues, the currently requested physical therapy is not medically necessary.

Functional Capacity Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 12. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter, Functional Capacity Evaluation.

Decision rationale: Regarding request for functional capacity evaluation, California Medical Treatment Utilization Schedule (MTUS) and American College of Occupational and Environmental Medicine (ACOEM) state that there is not good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. Official Disability Guidelines (ODG) states that functional capacity evaluations are recommended prior to admission to a work hardening program. The criteria for the use of a functional capacity evaluation includes case management being hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed explanation of a worker's abilities. Additionally, guidelines recommend that the patient be close to or at maximum medical improvement with all key medical reports secured and additional/secondary conditions clarified. Within the documentation available for review, there is no indication that there has been prior unsuccessful return to work attempts, conflicting medical reporting, or injuries that would require detailed exploration, and the patient does not appear to be close to or at MMI. In the absence of clarity regarding those issues, the currently requested functional capacity evaluation is not medically necessary.