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| Case Number: | CM14-0205617 | | |
| Date Assigned: | 12/17/2014 | Date of Injury: | 06/19/2013 |
| Decision Date: | 02/11/2015 | UR Denial Date: | 11/17/2014 |
| Priority: | Standard | Application Received: | 12/08/2014 |

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 Emergency 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 63 year-old female who sustained an injury on June 19, 2013. The mechanism of injury occurred while walking down steps. Diagnostics included diffuse facet arthropathy. Treatments have included: physical therapy, medications, orthotics. The current diagnosis is: pelvic arthropathy. The request for EMG of the bilateral upper extremities was denied on November 17, 2014, citing a lack of documentation of positive neurologic exam findings. The request for EMG of the bilateral lower extremities was denied on November 17, 2014, citing a lack of documentation of positive neurologic findings. The request for Wrist brace purchase was denied on November 17, 2014, citing a lack of documentation of medical necessity. The request for Interferential unit purchase was denied on November 17, 2014, citing a lack of documentation of medical necessity. The request for Hot/cold wrap purchase was denied on November 17, 2014, citing a lack of documentation of medical necessity. Per the report dated October 22, 2014, the treating physician noted complaints of right foot, right hip pain, and right hand/wrist pain. Exam shows right hip and lumbar reduced range of motion, decreased sensation right C5-6, right wrist tenderness, and normal lower extremities neurologic exam.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography (EMG) of the Bilateral Upper Extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 177-179, 268-269, 272-273.

Decision rationale: The requested electromyography (EMG) of the bilateral upper extremities is not medically necessary. The California MTUS Chronic Pain Treatment Guidelines, Chapter 11 - Forearm, Wrist, Hand Complaints, Special Studies and Diagnostic and Treatment Considerations, pages 268-269, 272-273; note 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 who would consider surgery an option, and recommend electrodiagnostic studies with documented exam findings indicative of unequivocal evidence of nerve compromise, after failed therapy trials, that are in need of clinical clarification. The injured worker has right foot, right hip pain, and right hand/wrist pain. The treating physician has documented right hip and lumbar reduced range of motion, decreased sensation right C5-6, right wrist tenderness, and normal lower extremities neurologic exam. The treating physician has not documented positive neurologic exam findings to the left upper extremity. The criteria noted above not having been met. Therefore, the request for EMG of the bilateral upper extremities is not medically necessary.

Electromyography (EMG) of the Bilateral Lower Extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The requested electromyography (EMG) of the bilateral lower extremities is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12, Low Back Complaints, page 303, Special Studies and Diagnostic and Treatment Considerations, note "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 who 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." The injured worker has right foot, right hip pain, and right hand/wrist pain. The treating physician has documented right hip and lumbar reduced range of motion, decreased sensation right C5-6, right wrist tenderness, and normal lower extremities neurologic exam. The treating physician has not documented physical exam findings indicative of nerve compromise such as a positive straight leg raising test or deficits in dermatomal sensation, reflexes or muscle strength. The criteria noted above not having been met. Therefore, the request for EMG of the bilateral lower extremities is not medically necessary.

Wrist brace purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

Decision rationale: The requested wrist brace purchase is not medically necessary. ACOEM and Official Disability Guidelines recommend this splint in cases of carpal tunnel syndrome. The injured worker has right foot, right hip pain, and right hand/wrist pain. The treating physician has documented right hip and lumbar reduced range of motion, decreased sensation right C5-6, right wrist tenderness, and normal lower extremities neurologic exam. The treating physician has not documented evidence of carpal tunnel syndrome. The criteria noted above not having been met. Therefore, the request for wrist brace purchase is not medically necessary.

Interferential unit purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential current stimulation Page(s): 118-120.

Decision rationale: The requested Interferential unit purchase, is not medically necessary. The California Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy, Interferential current stimulation, page 118-120, noted that this treatment is "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone... There are no published randomized trials comparing TENS to Interferential current stimulation;" and the criteria for its use are: "Pain is ineffectively controlled due to diminished effectiveness of medications; or - Pain is ineffectively controlled with medications due to side effects; or - History of substance abuse; or - Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or - Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.)." The injured worker has right foot, right hip pain, and right hand/wrist pain. The treating physician has documented right hip and lumbar reduced range of motion, decreased sensation right C5-6, right wrist tenderness, and normal lower extremities neurologic exam. The treating physician has not documented any of the criteria noted above, nor a current functional rehabilitation treatment program, nor derived functional improvement from electrical stimulation including under the supervision of a licensed physical therapist. The criteria noted above not having been met. Therefore, the request for interferential unit purchase is not medically necessary.

Hot/cold wrap purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174.

Decision rationale: The requested hot/cold wrap purchase is not medically necessary. The California MTUS, ACOEM 2nd Edition, 2004, Chapter 8, Neck and Upper Back Complaints, Initial Care, Physical Modalities, page 174, recommend hot and cold packs only for the first few days of initial complaints. The injured worker has right foot, right hip pain, and right hand/wrist pain. The treating physician has documented right hip and lumbar reduced range of motion, decreased sensation right C5-6, right wrist tenderness, and normal lower extremities neurologic exam. The treating physician has not documented the medical necessity for this DME beyond the initial first few days of treatment. The criteria noted above not having been met. Therefore, the request for hot/cold wrap purchase is not medically necessary.