

Case Number:	CM15-0186269		
Date Assigned:	09/28/2015	Date of Injury:	07/23/2015
Decision Date:	12/01/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	09/22/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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(n) 53 year old male, who sustained an industrial injury on 7-23-15. The injured worker was diagnosed as having lumbosacral sprain with radiculopathy, right shoulder strain, right hip strain, right knee strain and right hip strain. Treatment to date has included an x-ray of the lumbosacral spine and right hip (results not provided). As of the doctor's first report of injury dated 9-3-15, the injured worker reports pain in his right arm, elbow, hip, knee and lower back. Objective findings include a positive Cozen's test, "decreased" range of motion in the lumbar spine, right shoulder and right hip and a positive McMurray's test. There is also tenderness to palpation in the bilateral mid-lower thoracic region as well as the right elbow, right hip and right knee. The treating physician requested a hot and cold unit, a TENS unit, a right knee sleeve and an EMG-NCV of the bilateral lower extremities. The Utilization Review dated 9-10-15, non-certified the request for a hot and cold unit, a TENS unit, a right knee sleeve and an EMG-NCV of the bilateral lower extremities and certified the requests for physical therapy to the right elbow, shoulder, hip and knee x 4 sessions and physical therapy to the left shoulder and elbow x 4 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot and cold unit: 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) - Treatment in Workers' Comp 2012 on the web (www.odgtreatment.com) Work Loss Data Institute (www.worklossdata.com) (updated 02/14/12).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter/Cold/Heat Packs Section.

Decision rationale: MTUS guidelines support the use of at-home local applications of cold in first few days of acute complaint; thereafter, applications of heat or cold. The ODG supports the use of cold-packs as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint, thereafter, applications of heat packs or cold packs. The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. There is no indication that a commercially bought heat/ice unit has any advantage over an at-home application of ice or heat. The request for Hot and cold unit is not medically necessary.

Transcutaneous Electrical Nerve Stimulation (TENS) unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ODG Guidelines Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The use of TENS for chronic pain is not recommended by the MTUS Guidelines as a primary treatment modality, but a one-month home-based TENS trial may be considered if used as an adjunct to a program of evidence-based functional restoration in certain conditions. A home based treatment trial of one month may be appropriate for neuropathic pain and CRPS II and for CRPS I. There is some evidence for use with neuropathic pain, including diabetic neuropathy and post-herpetic neuralgia. There is some evidence to support use with phantom limb pain. TENS may be a supplement to medical treatment in the management of spasticity in spinal cord injury. It may be useful in treating MS patients with pain and muscle spasm. The criteria for use of TENS include chronic intractable pain (for one of the conditions noted above) with documentation of pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, a one month trial period of the TENS unit should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used as well as outcomes in terms of pain relief and function, and a treatment plan including specific short and long term goals of treatment. In this case, there is no evidence of a one-month home trial with a TENS unit. The request for Transcutaneous Electrical Nerve Stimulation (TENS) unit is not medically necessary.

Right knee sleeve: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation ODG-TWC Guidelines WEB Knee & Leg (Acute & Chronic) updated 03/31/14.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Activity Alteration.

Decision rationale: Per the MTUS Guidelines, the use of a knee brace is recommended for patellar instability, anterior cruciate ligament tear, or medial collateral ligament instability, although its benefits may be more emotional than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually unnecessary. In this case, there is no evidence of patellar or ligament instability. The request for right knee sleeve is not medically necessary.

Electromyography (EMG)/nerve conduction velocity (NCV) bilateral lower extremities:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG On-line; http://odg-twc.com/odgtwc/Low_Back.htm.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter/Nerve Conduction Studies (NCS) Section.

Decision rationale: Per the MTUS Guidelines, EMG may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The MTUS Guidelines do not specifically address nerve conduction studies of the lower extremities. Per the ODG, nerve conduction studies are not recommended because there is minimal justification of performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. In this case, there is no objective evidence, on physical examination, of neurologic dysfunction. The request for Electromyography (EMG)/nerve conduction velocity (NCV) bilateral lower extremities is not medically necessary.