

<b>Case Number:</b>	CM14-0121562		
<b>Date Assigned:</b>	09/22/2014	<b>Date of Injury:</b>	04/26/2010
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	07/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/31/2014

### 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 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 47-year-old female who reported an injury on 04/26/2010 due to the injured worker doing her usual and customary duties while washing some heavy grills. The injured worker had diagnoses of wrist sprain/strain, chronic pain syndrome of the wrist, myalgia/myositis not otherwise specified, brachial neuritis not otherwise specified, and sprain of the shoulder. Past medical treatment consists of surgery, chiropractic therapy, physical therapy, acupuncture, ultrasound/E stim, and medication therapy. Medications include omeprazole and tramadol. On 07/01/2014, the injured worker complained of right elbow and wrist pain. Examination of the wrist revealed tenderness to palpation over the carpal bones, thenar eminence, MCP joint, and brachioradialis muscle on the right. There was positive Tinel's, Phalen's, and Finkelstein's tests on the right. It was noted the injured worker had a range of motion which revealed flexion of 30 degrees, extension to 40 degrees, ulnar deviation to 20 degrees and radial deviation of 20 degrees. The treatment plan is for the injured worker to have additional use of a TENS unit, undergo a Functional Capacity Evaluation, continue with acupuncture, and have and EMG/NCV of the upper extremities. The rationale and request for authorization from were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME Purchase: TENS unit: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 116.

**Decision rationale:** The request for DME purchase of a TENS unit is not medically necessary. The California MTUS Guidelines do not recommend a TENS unit as a primary treatment modality. A 1 month home based TENS trial may be considered as a noninvasive conservative option, if they are used as an adjunct to a program of evidence based functional restoration. The results of studies are inconclusive, the published trials did not provide information on the simulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long term effectiveness. It was noted on physical examination that the injured worker had tenderness to palpation over the carpal bones, thenar eminence, MCP joint, and brachioradialis muscle on the right. It was also indicated that the injured worker had a positive Tinel's, Phalen's, and Finkelstein's tests on the right. However, there were no evidence or progress notes submitted for review on previous conservative treatment the injured worker has undergone. Additionally, it is unclear if the injured worker underwent and adequate TENS trial. The request as submitted is for the purchase of a TENS unit. Per the guidelines, a 1 month home based trial is recommended initially. Given the above, the injured worker is not within the MTSU recommended guidelines. As such, the request is not medically necessary.

**Functional Capacity Evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC Fitness for Duty Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional Capacity Evaluation

**Decision rationale:** The request for Functional Capacity Evaluation is not medically necessary. The CA MTUS/ACOEM states that a Functional Capacity Evaluation may be necessary to obtain a more precise delineation of a patient's capabilities. The Official Disability Guidelines further state that an FCE is recommended and may be used prior to admission to a work hardening program with preference for assessment tailored to a specific job or task. Functional Capacity Evaluations are not recommended for routine use. The submitted documentation lacked an indication of evidence of how a Functional Capacity Evaluation would aid the provider in evolving treatment plans or goals. Furthermore, there was a lack of documentation on other treatments the injured worker underwent previously and the measurement of progress as well as efficacy of the prior treatments. Additionally, the request had no indications or anything submitted or noted of reports that the injured worker was going to be attending a work hardening program. Given the above, the injured worker is not within recommended guidelines. As such, the request is not medically necessary.

**Acupuncture 2 times 4 for the right elbow, right wrist, and right shoulder:** 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 acupuncture 2 times a week for 4 weeks on the right elbow, right wrist, and right shoulder is not medically necessary. According to recommended guidelines, acupuncture is used as an option when pain medication is reduced or not tolerated. It must be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as followed: 1) time to produce functional improvement is usually 3 to 6 treatments, 2) is 1 to 3 times per week, and 3) optimum duration is 1 to 2 months. It was indicated in the submitted documentation that the injured worker had previous acupuncture therapy. There was no progress note submitted explaining efficacy or outcomes of such therapy. Additionally, it was not indicated how many sessions of acupuncture the injured worker had already attended. The request as submitted is for an additional 8 sessions of acupuncture. Given the above, it is unclear how the provider feels additional acupuncture would be beneficial to the injured worker. As such, the request is not medically necessary.

**EMG of upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 254. Decision based on Non-MTUS Citation ODG-TWC Forearm, Wrist and Hand Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines EMG Upper Extremity Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The request for an EMG of the upper extremities is not medically necessary. The CA MTUS/ACOEM Guidelines state that electromyography and nerve conduction velocities, including H reflex test, may help identify subtle, focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. It was noted in the submitted documentation that the injured worker had functional deficits upon physical examination. It was also noted that the injured worker had diagnosis of the wrist of myositis, and sprain/strain. It is unclear as to how the provider feels an EMG or NCV would be beneficial to the injured worker. According to ACOEM, EMGs/NCVs do not help diagnosis ligament/tendon strain, tendinitis, de Quervain's tendinitis, trigger finger, carpal tunnel, ganglion, or infection. Given the above, and lack of rationale, an EMG of the upper extremities is not warranted. As such, the request is not medically necessary.

**NCV of upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 254. Decision based on Non-MTUS Citation ODG-TWC Forearm, Wrist and Hand Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NCV Upper Extremity Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The request for an NCV of the upper extremities is not medically necessary. The CA MTUS/ACOEM Guidelines state that electromyography and nerve conduction velocities, including H reflex test, may help identify subtle, focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. It was noted in the submitted documentation that the injured worker had functional deficits upon physical examination. It was also noted that the injured worker had diagnosis of the wrist of myositis, and sprain/strain. It is unclear as to how the provider feels an EMG or NCV would be beneficial to the injured worker. According to ACOEM, EMGs/NCVs do not help diagnosis ligament/tendon strain, tendinitis, de Quervain's tendinitis, trigger finger, carpal tunnel, ganglion, or infection. Given the above, and lack of rationale, an NCV of the upper extremities is not warranted. As such, the request is not medically necessary.