MAXIMUS Federal Services

Case Number:	CM14-0160238		
Date Assigned:	10/03/2014	Date of Injury:	11/05/2013
Decision Date:	11/06/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/29/2014

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 & Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in Texas & Oklahoma. 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 49-year-old female who reported injuries after a trip and fall forward on 11/05/2013. On 07/23/2014, her diagnoses included right knee sprain/strain; internal derangement; left knee sprain/strain; lateral subluxing patella; degenerative joint disease; herniated lumbar disc with degenerative disc disease; spinal stenosis with radiculitis/ radiculopathy, herniated cervical disc C2-3; C3-4 degenerative disc disease; spinal stenosis C3-4, C4-5, and C5-6 with radiculitis/radiculopathy; cephalgia; bilateral wrist and hand sprain/strain; and tendonitis, rule out carpal tunnel syndrome. Her complaints included intermittent pain in the bilateral wrist and both hands radiating to her fingers rated at 5/10, constant neck pain travelling to her head and down her arms rated at 7/10, constant low back pain radiating to both legs, feet and toes rated at 9/10, constant right knee pain and intermittent left knee pain rated at 9/10 for the right knee and 7/10 for the left knee, constant headaches, anxiety, depression, and insomnia due to her pain. Her treatment plan recommendations and rationale included: EMG/NCV of the bilateral upper and lower extremities to establish the presence of radiculitis/neuropathy; a right knee brace, which was essential in providing stabilization to the knee; an IF unit for home use to help control pain and inflammation and increase circulation; an ultrasound guided corticosteroid injection to both knees for alleviation of pain and discomfort. A request for authorization dated 08/19/2014 was included in this injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG and NCV of bilateral upper and lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 182, 304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Low Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 272,.

Decision rationale: The request for EMG and NCV of bilateral upper and lower extremities is not medically necessary. The California ACOEM Guidelines note that nerve conduction velocity study is not recommended for all acute, sub acute, and chronic hand, wrist and forearm disorders. Electromyography/nerve conduction velocity (EMG/NCV) studies are only recommended for a diagnosis of carpal tunnel syndrome. Routine use of NCV or EMG in diagnostic evaluation of nerve entrapment or screening of patients without corresponding symptoms is not recommended. Regarding the lower extremities, there is no recommendation for or against the use of EMG for initial evaluation, diagnoses or preoperative assessment of tarsal tunnel syndrome in patients. Electromyography is not generally recommended as there is no quality evidence demonstrating the utility of EMG in a diagnosis of TTS. The guidelines do not support the use of electro diagnostic studies of the extremities. Therefore, this request for EMG and NCV of bilateral upper and lower extremities is not medically necessary.

Right knee brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339-340.

Decision rationale: The request for right knee brace is not medically necessary. The California ACOEM Guidelines recommend that a knee brace can be used 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 a 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. Upon examination it was noted that there was no instability of the medial or lateral collateral ligaments of the knees. There was no documentation submitted of patellar instability or anterior cruciate ligament tear. It was documented that this injured worker's employment is a desk job, and she would not be putting her knee under load. The guidelines do not support the use of a knee brace. Therefore, this request for right knee brace is not medically necessary.

IF unit (home use for 60 days): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119.

Decision rationale: The request for IF unit home use for 60 days is not medically necessary. The California MTUS Guidelines do not recommend interferential current stimulation as an isolated intervention. There are no standard protocols for the use of interferential therapy. The therapy may vary according to the frequency of stimulation, the pulse duration, treatment time and electrode placement technique. Additionally, the body part or parts for which this interferential unit was to have been applied was not specified, nor were there any parameters for frequency of stimulation, pulse duration, treatment time, or electrode placement. Therefore, this request for IF unit home use for 60 days is not medically necessary.

Ultrasound guided corticosteroid injection x 2 (both knees): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 346. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Corticosteroid injections.

Decision rationale: The request for ultrasound guided corticosteroid injection x 2 (both knees) is not medically necessary. The California ACOEM Guidelines note that corticosteroid injection is optional for all acute, subacute and chronic knee disorder. The Official Disability Guidelines recommends corticosteroid injections to the knee for short term use only. Intra-articular corticosteroid injections result in clinically and statistically significant reduction in osteoarthritic knee pain 1 week after injection. The beneficial effect could last for 3 to 4 weeks, but is unlikely to continue beyond that. The guidelines further note that intra-articular corticosteroid injections to the knees are generally performed without fluoroscopic or ultrasound guidance. This injured worker does not have a diagnosis of osteoarthritis of the knee. Additionally, the guidelines do not support ultrasound guided injections. This request is not supported by the guidelines. Therefore, this request for ultrasound guided corticosteroid injection x 2 (both knees) is not medically necessary.