

Case Number:	CM15-0078193		
Date Assigned:	04/29/2015	Date of Injury:	01/20/2014
Decision Date:	06/01/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/23/2015

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: Physical Medicine & Rehabilitation

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 43 year old male, who sustained an industrial injury on 1/20/14. He reported initial complaints of headache and left elbow. The injured worker was diagnosed as having cervicalgia, cervical radiculopathy; blunt head trauma; concussion; pain in the neck; cervical sprain/strain; muscle spasm of the neck; pain in left elbow; left elbow sprain/strain; swelling of left elbow; low back pain and left knee pain - nonindustrial. Treatment to date has included physical therapy; drug screening; medications. Diagnostics included CT scan of head (no report); MRI left elbow (no report); x-rays of cervical, lumbar and left knee (no report); MRI lumbar spine (7/26/14 - no report); MRI cervical spine (4/3/15). Currently, the PR-2 notes dated 3/17/15 indicated the injured worker complains of pain in lower back, left elbow and left knee. Examination of lumbosacral spine is with tenderness to palpation and can forward flex to floor; left elbow is with tenderness medially and laterally with full range of motion and left knee has no effusion, full range of motion and tenderness anteriorly. There were multiple radiographic/ diagnostic studies completed but there are no reports except for a Cervical spine MRI 4/3/15). All other study reports are documented in the context of the PR-2's submitted for review. A MRI scan lumbosacral spine shows a 2.6mm disc bulge at L5-S1 with some degenerative changes and x-rays show spondylosis that is mild. The MRI scan of the left elbow shows mild tendinosis with partial tear of the common extensor tendon origin. Qualified Medical Examination dated 2/11/15 documents no further treatment is necessary for left elbow. Injured workers complaints of low back and left knee are non-industrial causation and shoulder be done on a non-industrial basis. The provider is requesting an EMG/NCS of the upper extremities, Purchase of a Counterforce strap (left elbow) and Referral to Neurology.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCS of the upper extremities: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262.

Decision rationale: The patient presents with lower back, left elbow, and left knee pain. The request is for EMG/NCS OF THE UPPER EXTREMITIES. The request for authorization is dated 03/17/15. MRI of the cervical spine, 04/03/15, shows minor degenerative changes of the cervical spine and no compromise of the neural foramen or central canal at any level. MRI of the left elbow, date unspecified, shows mild tendinosis and partial tear of the common extensor tendon origin. Physical examination of the left elbow reveals tenderness medially and laterally. He has full range of motion. Decreased sensation over the pinky and ring finger. Positive Tinel's. He has trouble concentrating and remembering things. He feels sad, discouraged, and tense due to his injuries. He will initiate physical therapy two times a week for six weeks. Patient's medications include Ranitidine and Omeprazole. Per progress report dated 03/17/15, the patient is temporarily totally disabled. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electro diagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." Per progress report dated 03/17/15, treater's reason for the request is "I need this study to further evaluate the numbness and tingling in his left hand." Given the patient's upper extremity symptoms, physical examination findings and diagnosis, EMG/NCS studies would appear reasonable. In this case, there is no evidence that this patient has had prior upper extremity EMG/NCV studies done. The request appears to meet guideline criteria. Therefore, the request IS medically necessary.

Purchase of a Counterforce strap: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Elbow chapter, Splinting.

Decision rationale: The patient presents with lower back, left elbow, and left knee pain. The request is for PURCHASE OF A COUNTERFORCE STRAP. The request for authorization is dated 03/17/15. MRI of the cervical spine, 04/03/15, shows minor degenerative changes of the cervical spine and no compromise of the neural foramen or central canal at any level. MRI of the left elbow, date unspecified, shows mild tendinosis and partial tear of the common extensor tendon origin. Physical examination of the left elbow reveals tenderness medially and laterally. He has full range of motion. Decreased sensation over the pinky and ring finger. Positive Tinel's. He has trouble concentrating and remembering things. He feels sad, discouraged, and tense due to his injuries. He will initiate physical therapy two times a week for six weeks. Patient's medications include Ranitidine and Omeprazole. Per progress report dated 03/17/15, the patient is temporarily totally disabled. ODG Guidelines, Elbow chapter, under Splinting states the following: "Recommended for cubital tunnel syndrome, including a splint or foam elbow pad worn at night, and/or an elbow pad to protect against chronic irritation from hard surfaces. Under study for epicondylitis. No definitive conclusions can be drawn concerning effectiveness of standard braces or splints for lateral epicondylitis. If used, bracing or splinting is recommended only as short-term initial treatment for lateral epicondylitis in combination with physical therapy. Some positive results have been seen with the development of a new dynamic extensor brace but more trials need to be conducted. Initial results show significant pain reduction, improved functionality of the arm, and improvement in pain-free grip strength. The beneficial effects of the dynamic extensor brace observed after 12 weeks were significantly different from the treatment group that received no brace. The beneficial effects were sustained for another 12 weeks. Static progressive splinting can help gain additional motion when standard exercises seem stagnant or inadequate, particularly after the original injury. Operative treatment of stiffness was avoided in most patients. These results differ from studies testing standard bracing which showed little to no effect on pain." Per progress report dated 03/17/15, treater's reason for the request is "for his lateral epicondylitis." In this case, physical examination reveals tenderness medially and laterally with decreased sensation over the pinky and ring finger and positive Tinel's sign. ODG guidelines recommends the use of bracing for lateral epicondylitis in combination with physical therapy. Given the patient's left elbow symptoms, physical examination findings and diagnosis, the purchase of a counterforce strap would appear reasonable. Therefore, the request IS medically necessary.

Referral to Neurology: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Independent medical examination and consultations. Ch:7 page 127.

Decision rationale: The patient presents with lower back, left elbow, and left knee pain. The request is for REFERRAL TO NEUROLOGY. The request for authorization is dated 03/17/15. MRI of the cervical spine, 04/03/15, shows minor degenerative changes of the cervical spine and no compromise of the neural foramen or central canal at any level. MRI of the left elbow, date unspecified, shows mild tendinosis and partial tear of the common extensor tendon origin.

Physical examination of the left elbow reveals tenderness medially and laterally. He has full range of motion. Decreased sensation over the pinky and ring finger. Positive Tinel's. He has trouble concentrating and remembering things. He feels sad, discouraged, and tense due to his injuries. He will initiate physical therapy two times a week for six weeks. Patient's medications include Ranitidine and Omeprazole. Per progress report dated 03/17/15, the patient is temporarily totally disabled. ACOEM Practice Guidelines, 2nd Edition (2004), page 127 has the following: "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." Treater does not discuss the request. There is no discussion as to why neurology consultation is needed. While specialty consultation is supported by the guidelines, the request needs to be appropriate and indication must be present. Based on this patient's list of complaints, it is not known what a neurologist can do to help the patient. The request IS NOT medically necessary.