
Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/31/2013

IMR Case Number:	CM13-0012238	Date of Injury:	04/10/2013
Claims Number:	[REDACTED]	UR Denial Date:	07/24/2013
Priority:	Standard	Application Received:	08/16/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED]		
Treatment(s) in Dispute Listed on IMR Application:	EMG of bilateral upper extremities, Terocin (topical) 120ml, TENS unit trial		

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: PARTIAL OVERTURN. This means we decided that some (but not all) of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in PM&R, and is licensed to practice in Pennsylvania. 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The underlying date of injury in this case is 04/10/2013. This patient is a 38-year-old man who has reported right hand pain. On exam he has been noted to be tender on the ulnar aspect of the right hand and the internal right elbow with reduced grip strength. Ibuprofen has caused stomachache.

An initial physician reviewer recommended non-certification of this request for reasons including the California Medical Treatment Utilization Schedule did not provide recommendations for the use of upper extremity electrodiagnostic studies. The reviewer also stated that the use of a TENS unit was not proven effective since TENS has not been proven effective in treating acute hand injuries

IMR DECISION(S) AND RATIONALE(S)

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

1. EMG of the bilateral upper extremities is medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines, Chapter 11, Forearm, Wrist and Hand Complaints, page 261, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8) pg 178, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The ACOEM Guidelines, Chapter 8 Neck, page 178, states, "Electromyography and nerve conduction velocities may help identify subtle focal and neurological dysfunction in patients with neck or arm symptoms or both lasting more than 3 or 4 weeks." The initial reviewer states

that this guideline does not apply to bilateral upper extremity studies. There is no restriction in the guideline to apply to bilateral studies. Moreover, as a fundamental principle, if an electrodiagnostic study is abnormal on one part of the body, then it would be appropriate to compare it to the other side, just as a physician doing a physical examination would compare strength, for example, on an abnormal side to strength on the opposite side. The reported symptoms and physical exam findings at this time are consistent with the guidelines for an electrodiagnostic study. This request is medically necessary.

2. Tercoïn (topical) 120ml is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, page 111, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The California Medical Treatment Utilization Schedule, Chronic Pain Medical Treatment Guidelines Section on Topical Analgesics, page 111, states, "The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required." The medical records do not provide a specific rationale for Terocin consistent with these guidelines. This request is not medically necessary.

3. TENS unit trial is medically necessary and appropriate.

The Claims Administrator based its decision on the ACOEM Guidelines, Chapter 11, Forearm, Wrist and Hand Complaints, page 265, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section on TENS, page 114, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The Chronic Pain Medical Treatment Guidelines Section on TENS, page 114, states, "a one-month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration for the conditions described below." Those described conditions include neuropathic pain. This patient has specific medical records indicating a possible neuropathic upper extremity pain. A prior reviewer indicated that TENS is not supported by guidelines for hand conditions, although it is not evident the basis of that conclusion. Overall, the medical records and guidelines do support this request. This request is medically necessary.

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

[REDACTED]

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