

<b>Case Number:</b>	CM13-0021465		
<b>Date Assigned:</b>	06/06/2014	<b>Date of Injury:</b>	03/20/2013
<b>Decision Date:</b>	07/31/2014	<b>UR Denial Date:</b>	08/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2013

### 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 Pain Management, Physical Medicine and Rehabilitation; has a subspecialty in Interventional Spine 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 patient is a 53 year old female with an injury date on March 20, 2013. The patients diagnoses include right shoulder strain and bilateral carpal tunnel syndrome. The patient has complaints of right shoulder pain. The patient is on modified work with restriction of no lifting, carrying, pushing, or pulling anything heavier than 10-pounds. The patient also has swelling of the right shoulder, mild tenderness to palpation and a positive impingement sign. Tinel sign and Phalen test were positive in the right/left wrist. Diminished pinprick to the median nerve distribution of the right/left wrist was also noted. [REDACTED] is requesting a Functional Capacity Evaluation, 6 sessions of functional restoration programs for the right shoulder, 4 sessions of electrical muscle stimulator, 4 sessions of myofascial releases, 4 sessions of paraffin wax, 12 sessions of therapeutics strengthening exercises, neurodiagnostic study of the forearm, wrist, and hand and an MRI of the right shoulder. The utilization review denied the request on August 27, 2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**A Functional Capacity Evaluation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional improvement measures Page(s): 48.

**Decision rationale:** According to the August 26, 2013, report by [REDACTED] this patient presents with right shoulder pain. The request is for a Functional Capacity Evaluation (FCE). Guidelines state that as with any behavior, an individual's performance on an FCE is probably influenced by multiple nonmedical factors other than physical impairments. For these reasons, it is problematic to rely solely upon the FCE results for determination of current work capability and restrictions. It is the employer's responsibility to identify and determine whether reasonable accommodations are possible to allow the examinee to perform the essential job activities. In this case, the patient has returned to work and it is the employer's responsibility to identify and determine whether reasonable accommodations are possible. Furthermore, the treating physician does not explain why a Functional Capacity Evaluation is needed. Therefore, the request is not medically necessary.

**A Functional Restoration for the Right Shoulder (6-sessions): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs) Page(s): 49.

**Decision rationale:** According to the August 26, 2013, report by [REDACTED] this patient presents with right shoulder pain. The request is for 6 sessions of functional restoration programs for the right shoulder. According to guidelines functional restoration programs may be considered medically necessary when all criteria are met including (1) adequate and thorough evaluation has been made (2) Previous methods of treating chronic pain have been unsuccessful (3) significant loss of ability to function independently resulting from the chronic pain; (4) not a candidate for surgery or other treatments would clearly be (5) The patient exhibits motivation to change (6) Negative predictors of success above have been addressed. Review of the reports does not indicate that the patient has met all of the criteria. Without accomplishing all six criteria of the California MTUS guidelines, the request cannot be recommended for authorization. Furthermore, the reports seem to indicate that the patient has returned to modified work. A functional restoration program would not be indicated if the patient has already returned to work. Therefore, the request is not medically necessary.

**Four (4) Sessions of Electrical Muscle Stimulation: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

**Decision rationale:** According to the August 26, 2013, report by [REDACTED] this patient presents with right shoulder pain. The request is for 4 sessions of electrical muscle stimulator. Chronic Pain Medical Treatment Guidelines do not support muscle stimulation, or NMES (neuromuscular electrical stimulation) except for rehabilitation following stroke. It is not recommended for chronic pain. Therefore, the request is not medically necessary.

**Four (4) Sessions of Myofascial Release: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy and Manipulation Page(s): 60.

**Decision rationale:** According to the August 26, 2013, report by [REDACTED] this patient presents with right shoulder pain. The current request 4 sessions of myofascial release but the treating physician's report and request for authorization containing the request is not included in the file. According to the Chronic Pain Medical Treatment Guidelines massage therapy is recommended as an option; but the treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. In this case, review of the medical file does not show any sessions of myofascial release or any discussions thereof. It is possible that the patient has had myofascial release therapy in the past with the documentation not provided. However, given that the review of the current reports make no reference to a recent course of therapy, a short course may be reasonable. Therefore, the request is medically necessary.

**Four (4) Sessions of Paraffin Wax: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist & Hand (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Paraffin wax for hands; as well as Aetna Guidelines on heating devices.

**Decision rationale:** According to the August 26, 2013, report by [REDACTED] this patient presents with right shoulder pain. The request is for 4 sessions of paraffin wax. The Official Disability Guidelines recommend paraffin wax as an option for arthritic hands if used as an adjunct to a program of evidence-based conservative care (exercise). Review of the reports does not show arthritis of the hands as diagnosis. Furthermore, Aetna Guidelines on heating devices considers portable paraffin baths medically necessary durable medical equipment for members who have undergone a successful trial period of paraffin therapy and the member's condition (e.g., severe rheumatoid arthritis of the hands) is expected to be relieved by long-term use of this modality. In this case, given that the patient does not present with arthritic hands, the use of paraffin wax does not appear indicated. Therefore, the request is not medically necessary.

## **Twelve (12) Sessions of Therapeutics Strengthening Exercises: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise and Physical Medicine Page(s): 46-47, 98-99.

**Decision rationale:** According to the August 26, 2013, report by [REDACTED] this patient presents with right shoulder pain. The request is for 12 sessions of therapeutics strengthening exercises. Chronic Pain Medical Treatment Guidelines states that exercise is recommended. Evidence based guidelines indicate that there is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated. Such programs should emphasize education, independence, and the importance of an on-going exercise regimen. Review of the reports shows that the patient has returned to modified work, and continues to take medications. It is not known whether or not the patient is doing home exercises. While a short course of therapeutic exercise training may be reasonable, the current request for 12 sessions exceeds what is allowed by the California MTUS Guidelines for the number of therapy sessions. Therefore, the request is not medically necessary.

## **Neurodiagnostic Studies of the Forearm, Wrist, and Hand: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

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

**Decision rationale:** According to the August 26, 2013, report by [REDACTED] this patient presents with right shoulder pain. The current request is for a neurodiagnostic study of the forearm, wrist, and hand. Guidelines state that appropriate electrodiagnostic studies (EDS) may help differentiate between carpal tunnel syndrome (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. An 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. Review of the reports show that the patient had a neurodiagnostic study done on June 21, 2013, which was consistent with moderate bilateral carpal tunnel syndrome. The report was not available for this review. In this case, a repeat study of the same body parts is not needed. Therefore, the request is not medically necessary.

## **An MRI of the Right Shoulder: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

**Decision rationale:** According to the August 26, 2013, report by [REDACTED] this patient presents with right shoulder pain. The request is for an MRI of the right shoulder. The ACOEM Practice Guidelines state that the criteria for ordering imaging studies include an acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs; and subacute shoulder pain, suspect instability/labral tear. Review of the reports show that the patient had impingement of the shoulder and is over the age 40. In this case, the patient meets the criteria for ordering the MRI; therefore the request is medically necessary.