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| <b>Case Number:</b>   | CM13-0022595 |                              |            |
| <b>Date Assigned:</b> | 11/13/2013   | <b>Date of Injury:</b>       | 07/17/2011 |
| <b>Decision Date:</b> | 01/30/2014   | <b>UR Denial Date:</b>       | 07/25/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/10/2013 |

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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. 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 65-year-old male who reported an injury on 06/13/2010 due to repetitive trauma while performing normal job duties. The patient reportedly sustained an injury to the right elbow, right knee, and right shoulder. The patient underwent surgical intervention of the right knee followed by postoperative physical therapy. The patient underwent corticosteroid injections for the right elbow. The patient's most recent clinical exam findings included a positive impingement sign, positive supraspinatus sign, positive acromioclavicular joint compression test to the right shoulder, and range of motion described as 80 degrees in flexion, 40 degrees in extension, 80 degrees in abduction, 30 degrees in adduction, and 50 degrees in internal and external rotation. The patient's diagnoses included right shoulder rotator cuff tendinitis, right tennis elbow syndrome with lateral epicondylitis, right wrist tendinitis, and bilateral knee degenerative arthritis with degenerative meniscal tears. The patient's treatment plan included surgical intervention of the right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional Capacity Evaluation (FCE):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-79. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for duty chapter, Functional Capacity Evaluation (FCE).

**Decision rationale:** The requested Functional Capacity Evaluation is not medically necessary or appropriate. The patient does continue to have significant deficits that require continued medical management. American College of Occupational and Environmental Medicine recommends the use of a Functional Capacity Evaluation to obtain a more delineation of patient capabilities that is available from routine physical examination and notes; under some circumstances, this can be best done by ordering a Functional Capacity Evaluation of the patient. However, the clinical documentation submitted for review does not provide any evidence that the patient has exhausted all conservative measures and has the intention of re-entering the work force. Official Disability Guidelines recommend Functional Capacity Evaluations if the patient is close or at maximum medical improvement. As the patient continues to be a surgical candidate, the timing of this Functional Capacity Evaluation does not appear to be medically necessary or appropriate.

**acupuncture 3-6 treatments:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The requested acupuncture 3 to 6 treatments is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient is a surgical candidate and has chronic pain. However, the clinical documentation submitted for review does provide evidence the patient has had extensive acupuncture treatments. Significant functional benefit or medication reduction as result of the prior acupuncture is not provided within the documentation submitted for review. California Medical Treatment Utilization Schedule states continuation of acupuncture treatments should be based on significant functional gains and medication reduction. As the documentation does not provide evidence of any significant functional benefit or reduction in medications, continuation of this treatment would not be indicated. As such, the requested acupuncture 3 to 6 treatments is not medically necessary or appropriate.

**TENS's supplies per month:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Page(s): 114-146.

**Decision rationale:** The requested TENS unit supplies per month is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient is scheduled to undergo shoulder surgery. California Medical Treatment Utilization

Schedule does recommend the use of a TENS unit for 30 days status post a surgical procedure. However, as the patient has multiple pain generators, the necessity of the requested TENS unit is not specifically identified. California Medical Treatment Utilization Schedule recommends a 30 days trial be used as an adjunct therapy to other functional restoration treatments. The clinical documentation submitted for review does not provide any evidence the patient has undergone a 30 days trial to support monthly supplies for a TENS unit. As such, the requested TENS supplies per month is not medically necessary or appropriate.

**chiropractic care sessions 1 time a week for 6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Manual Therapy Page(s): 58.

**Decision rationale:** The requested chiropractic care sessions 1 time a week for 6 weeks is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has multiple pain generators to include the right shoulder, right wrist, right elbow, and right knee. California Medical Treatment Utilization Schedule does not recommend chiropractic care for the elbow, wrist, or knee. As the patient is a surgical candidate for the right shoulder, the need for chiropractic treatment is not clearly identified within the documentation. As the specific body part is not identified by the request, determination for safety and efficacy cannot be provided. As such, the requested chiropractic care sessions 1 time a week for 6 weeks is not medically necessary or appropriate.

**electrical stimulation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Page(s): 114.

**Decision rationale:** The clinical documentation submitted for review does provide evidence that the patient is a surgical candidate for right shoulder surgery. California Medical Treatment Utilization Schedule does recommend a 30 days duration of use of a TENS unit in the postsurgical management of the patient's pain. However, as the patient has multiple pain generators and it is not clearly identified within the request the intention of treatment, the need for the TENS unit is unclear. California Medical Treatment Utilization Schedule recommends the use of a TENS unit be based on a 30 days trial that provides significant functional benefit as an adjunct therapy to a Functional Restoration Program. The clinical documentation submitted for review does not provide any evidence of a 30 days trial. Therefore, electrical stimulation would not be medically necessary or appropriate.

**neuromuscular reeducation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section TENS Unit Page(s): 114.

**Decision rationale:** As the requested TENS unit is not medically necessary or appropriate for this patient at this time, the decision for neuromuscular re-education is also not medically necessary or appropriate at this time.

**Capsaicin 0.025% topical cream:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 28 of 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The requested capsaicin 0.25% topical cream for chronic pain of the right wrist/shoulder/hand/elbow is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been using this topical agent for an extended duration. However, pain relief and functional benefit related to this medication is not provided. Also, California Medical Treatment Utilization Schedule does not recommend the use of capsaicin as a topical agent unless the patient has failed to respond to other types of treatments including oral analgesics. The clinical documentation submitted for review does not support the patient has failed to respond to oral analgesics. As such, the requested prescription for capsaicin 0.025%, topical cream for chronic pain, right wrist/shoulder/hand/elbow is not medically necessary or appropriate at this time.