

Case Number:	CM13-0061007		
Date Assigned:	12/30/2013	Date of Injury:	08/21/2013
Decision Date:	04/10/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	12/04/2013

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 Anesthesiology, Pain Management, 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 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 51-year-old male who reported an injury on 08/2/12013. The mechanism of injury was not specifically stated. The patient is diagnosed with eye pain, visual disturbance, right shoulder impingement syndrome, right shoulder tenosynovitis, right elbow medial epicondylitis, right wrist pain, lumbar spine sprain, bilateral hip pain, and bilateral knee sprain. The only documentation submitted for this review is a Doctor's First Report of Occupational Injury or Illness submitted on 10/09/2013 by [REDACTED]. The patient reported persistent pain over multiple areas of the body. Physical examination revealed slight crepitus with range of motion of the shoulder, 2+ tenderness at the AC joint, decreased range of motion, positive Neer's testing, 3+ tenderness over the medial epicondyle, decreased range of motion, positive valgus stress testing, 2+ tenderness at the course of the 5th metacarpal, diminished sensation, decreased strength, bilateral lumbar paraspinal muscle guarding, decreased range of motion, positive straight leg raise, tenderness over the bilateral hips, 2+ tenderness over the medial and lateral joint line, decreased range of motion, diminished sensation, and decreased motor strength. Treatment recommendations included x-rays, TENS unit, hot and cold unit, physical therapy, acupuncture, shockwave treatment, a Functional Capacity Evaluation, ophthalmology consultation, MRI, and Electromyography (EMG)/Nerve Conduction Velocity (NCV) study.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS/EMS unit with 2 month supplies electrodes, batteries, lead wires: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based trial may be considered as a non-invasive conservative option. There is no documentation of pain that has persisted for at least months in duration. There is also no evidence that other appropriate pain modalities have been tried and failed. The current request for a TENS unit for 2 months exceeds guideline recommendations. There was also no treatment plan including the specific short-term and long-term goals of treatment with the unit provided. Based on the clinical information received, the request is non-certified.

X-rays of unspecified body parts: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: California MTUS/ACOEM Practice Guidelines state lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology. As per the documentation submitted, the patient reports persistent pain over multiple areas of the body. However, there is no documentation of what body part is to be x-rayed. Therefore, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.

Physical Therapy 2 x 4 right shoulder/elbow/wrist/lumbar spine and bilateral knees:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for fading of treatment frequency, plus active, self-directed home physical medicine. As per the documentation submitted, the patient reports persistent pain over multiple areas of the body. The patient demonstrates decreased range of motion of the lumbar spine, shoulder, and bilateral knees. While the patient may meet criteria for an initial trial of physical therapy, the current

request for 8 sessions of treatment cannot be determined as medically appropriate. Therefore, the request is non-certified.

Acupuncture 2 x 4 right shoulder/elbow/wrist/lumbar spine and bilateral knees: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: California MTUS Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated and may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The time to produce functional improvement includes 3 to 6 treatments. The current request for 8 sessions of acupuncture treatment exceeds guideline recommendations. Therefore, the request is non-certified.

Shockwave treatment of unspecified body parts.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, Shoulder Chapter, Extracorporeal Shock Wave Therapy (ESWT).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205..

Decision rationale: California MTUS/ACOEM Practice Guidelines state there is medium quality evidence to support extracorporeal shockwave therapy for calcifying tendinitis of the shoulder. As per the documentation submitted, the patient reports persistent pain over multiple areas of the body. However, there is no specific body part listed for which shockwave treatment is to be provided. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

Functional Capacity Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: California MTUS/ACOEM Practice Guidelines state a number of functional assessment tools are available including Functional Capacity Evaluation when reassessing function and functional recovery. Official Disability Guidelines state a Functional Capacity Evaluation should be considered if case management is hampered by complex issues and the timing is appropriate. As per the documentation submitted, there is no evidence of

previous unsuccessful return to work attempts. There is also no indication that this patient has reached or is close to maximum medical improvement. There is no evidence of a defined return to work goal or job plan which has been established, communicated, and documented. Based on the clinical information received, the request is non-certified.