MAXIMUS Federal Services

Case Number:	CM14-0109643		
Date Assigned:	08/01/2014	Date of Injury:	09/10/2012
Decision Date:	09/24/2014	UR Denial Date:	07/09/2014
Priority:	Standard	Application Received:	07/15/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 injured worker is a 48-year-old male, who reported an injury on 09/10/2012; while doing his customary duties, he developed low back pain. The injured worker's job was to break down, assemble, and load heavy machinery. Diagnosis was lumbar spine sprain/strain with myospasm. Past treatment was physical therapy, lumbar epidural steroid injection, and acupuncture. Diagnostic studies were MRI of the lumbar spine without contrast on 12/27/2012. The impression was chronic spondylotic changes, more prominent in lower lumbar level; disc desiccation, disc space narrowing, and chronic endplate changes L5-S1 with neural foraminal narrowing without central canal stenosis; disc desiccation and mild neural foraminal narrowing L4-5 bilaterally; subtle chronic changes at L2-3 without significant central canal stenosis. Past surgery was right foot surgery in 1994. Physical examination on 06/23/2014 revealed complaints of low back pain, which was rated a 5/10 and constant at a 3/10. The pain radiated to bilateral legs. The injured worker denied numbness or tingling sensation. Examination of the spine revealed tenderness to palpation with spasm of the paraspinals. There was tenderness to palpation of bilateral sacroiliacs. Range of motion for flexion was to 45 degrees; extension was to 15 degrees; right flexion was to 20 degrees; and, left flexion was to 20 degrees. Straight leg raise test was to 45 degrees on the right. Pinwheel sensory dermatomes L1-S1 were intact. Reflexes for patellar at the L4 and Achilles S1 were equal and symmetrical. Motor strength was a 3+/5. Medication was hydrocodone/APAP 5 mg/325 mg. Treatment plan was for acupuncture and functional capacity evaluation. The rationale was not submitted. The Request for Authorization was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture 2x6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: California Medical Treatment Utilization Schedule Guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated and it is recommended as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The time to produce functional improvement is 3 to 6 treatments, and acupuncture treatments may be extended if functional improvement is documented, including either a clinically significant improvement in activities of daily living or a reduction in work restrictions. There were no reports of functional improvement from the previous acupuncture treatments. Therefore, the request for Acupuncture 2x6 is not medically necessary.

Functional Capacity Evaluation with impairment rating: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Capacity Evaluation Page(s): 125. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index , 12th Edition (web), 2014, Fitness for Duty, FCE.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional Capacity Evaluation.

Decision rationale: ACOEM guidelines indicate there is a functional assessment tool available and that is a Functional Capacity Evaluation, however, it does not address the criteria. As such, secondary guidelines were sought. Official Disability Guidelines indicates that a Functional Capacity Evaluation is appropriate when a worker has had prior unsuccessful attempts to return to work, has conflicting medical reports, the patient had an injury that required a detailed exploration of a workers abilities, a worker is close to maximum medical improvement and/or additional or secondary conditions have been clarified. However, the evaluation should not be performed if the main purpose is to determine a worker's effort or compliance or the worker has returned to work and an ergonomic assessment has not been arranged. It is recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. It is recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. The medical necessity was not clearly reported by the provider for the functional capacity evaluation with impairment. Future medical treatment was reported as acupuncture. It was not noted that the intentions for this

request was to eventually progress to a work hardening program. Therefore, the request for Functional Capacity Evaluation with Impairment Rating is not medically necessary.

Hydrocodone/ APAP 5/ 325mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen; Ongoing Management Page(s): 91; 78.

Decision rationale: California MTUS guidelines recommend hydrocodone/acetaminophen for moderate to moderately severe pain and it indicates that for ongoing management, there should be documentation of the 4 A's including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. The "4 A's" were not reported. Therefore, the request for Hydrocodone/APAP 5/325mg quanity 30 is not medically necessary.

Urine Drug Screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Page(s): 78.

Decision rationale: California MTUS indicates that the use of drug screening is for patients with documented issue of abuse, addiction, or poor pain control. It was not reported that the injured worker presented aberrant drug behavior. Therefore, the request for Urine Drug Screen is not medically necessary.

Range of motion and muscle testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment index, 12th Edition (web), 2014, Low Back, Flexibility.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Flexibility.

Decision rationale: The California MTUS does not address this request. Not recommended as a primary criteria, but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent. This has implications for clinical practice as it relates to disability determination for patients with chronic low back pain, and perhaps for the current impairment guidelines of the American Medical Association. The value of the sit-and-reach test as an indicator of previous back discomfort is

questionable. The AMA Guides to the Evaluation of Permanent Impairment, 5th edition, state, "an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical and inexpensive way" (p 400). They do not recommend computerized measures of lumbar spine range of motion which can be done with inclinometers, and where the result (range of motion) is of unclear therapeutic value. Measurement of three dimensional real time lumbar spine motion including derivatives of velocity and acceleration has greater utility in detecting patients with low back disorder than range of motion. The medical necessity was not reported. The medical guidelines do not support this request. Therefore, the request for Range of Motion Muscle Testing is not medically necessary.