

Case Number:	CM14-0014605		
Date Assigned:	06/04/2014	Date of Injury:	02/27/2013
Decision Date:	07/31/2014	UR Denial Date:	01/31/2014
Priority:	Standard	Application Received:	02/05/2014

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 and is licensed to practice in Illinois. 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 32-year-old female with a reported injury on 02/27/2013. The mechanism of injury was not provided within the clinical notes. The clinical note dated 01/22/2014 reported that the injured worker complained of bilateral upper extremity pain. The physical examination of the injured worker's cervical spine revealed range of motion demonstrating flexion to 60 degrees, extension to 60 degrees, lateral bend 25 degrees bilaterally, and rotation to 85 degrees bilaterally. The examination of the injured worker's shoulders revealed an active range of motion demonstrating abduction to 180 degrees, external rotation to 65 degrees, internal rotation to 85 degrees, forward flexion to 180 degrees, extension to 50 degrees, and adduction to 45 degrees. The physical assessment of the injured worker's bilateral shoulders was negative for any significant abnormalities. The injured worker's diagnoses included shoulder arthralgia, (unspecified) peripheral neuropathy, and electrocution and nonfatal effects of electric current. The provider requested additional acupuncture, physical therapy, and pain management consultation; to increase strengthening and treat the injured worker's chronic neuropathic pain. The request for authorization was submitted 01/31/2014. The injured worker's prior treatments included previous acupuncture.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACUPUNCTURE X6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for ACUPUNCTURE X6 is non-certified. The injured worker complained of bilateral upper extremity pain. The treating physician's rationale for additional acupuncture is for the treatment of pain. The CA MTUS guidelines recognize acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. 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. There is a lack of clinical evidence indicating that the injured worker has had a reduction in pain medication as a result of acupuncture therapy. Given the information provided, there is insufficient evidence to determine the appropriateness of additional acupuncture therapy to warrant medical necessity; as such, the request is non-certified.

PHYSICAL THERAPY 2 X 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 474.

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

Decision rationale: The request for Physical Therapy 2 X 4 is non-certified. The injured worker complained of bilateral upper extremity pain. The treating physician's rationale for physical therapy is for strengthening. The CA MTUS guidelines recognize active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Within the provided documentation, an adequate and complete assessment of the injured worker's functional condition is not provided; there is a lack of documentation indicating the injured worker has significant functional deficits. Furthermore, the requesting provider did not indicate the specific extremity or extremities requiring strengthening and increased range of motion necessary for physical therapy sessions. Given the information provided, there is insufficient evidence to determine appropriateness of physical therapy to warrant medical necessity; as such, the request is non-certified.

PAIN MANAGEMENT CONSULT FOR LEFT SHOULDER AND WRIST: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM GUIDELINES, CHAPTER 7.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

Decision rationale: The request for PAIN MANAGEMENT CONSULT FOR LEFT SHOULDER AND WRIST is non-certified. The injured worker complained of bilateral upper extremity pain. The treating physician's rationale for pain management is for the treatment of pain. The CA MTUS guidelines state the consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. The treating physician's rationale for pain management consultation for the left shoulder and wrist is for the treatment of pain. There is a lack of clinical evidence that the injured worker's pain was unresolved with the primary physician's standardized care. The injured worker's prescribed medication regimen was not provided within a recent clinical note. There is a lack of clinical information indicating the injured worker's neuropathic pain was unresolved with their prescribed medication. Given the information provided, there is insufficient evidence to determine appropriateness of pain management consultation to warrant medical necessity; as such, the request is non-certified.