

Case Number:	CM14-0018902		
Date Assigned:	04/23/2014	Date of Injury:	08/08/2013
Decision Date:	07/03/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	02/14/2014

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 Internal Medicine, has a subspecialty in Emergency 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 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:

This patient is a 34 year-old with a date of injury of 08/08/13. The most recent evaluation report that was dated prior to the RFA was 09/14/13. The RFA was dated 01/07/14. It identified subjective complaints of low back and bilateral hand pain. Objective findings included normal range-of-motion of the lumbar spine. No tenderness is mentioned. Range-of-motion of the wrists was also normal. Tinel's sign was positive. An MRI on 09/30/13 revealed multi-level lumbar disc protrusion. Diagnoses included lumbar disc disease and wrist sprain/strain. Treatment has included oral analgesics and muscle relaxants. The determination at the time of that evaluation was that the claimant was temporarily totally disabled pending a re-evaluation. A Functional Capacity Evaluation was recommended at that visit. A Utilization Review determination was rendered on 01/22/14 recommending non-certification of "Functional Capacity Evaluation; physiotherapy (2) times a week for (6) weeks for the lumbar spine and bilateral wrist; acupuncture (1) time a week for (6) weeks for the lumbar spine and bilateral wrist; Interferential Unit- rent for 12 months; neurostimulator TENS/EMS attachment- rent for 12 months".

IMR ISSUES, DECISIONS AND RATIONALES

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

FUNCTIONAL CAPACITY EVALUATION: 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) Fitness for Duty Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 81, Chronic Pain Treatment Guidelines Work Conditioning, Work Hardening Page(s): 125. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional Capacity Evaluation.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that a Functional Capacity Evaluation (FCE) may be necessary as part of a work hardening program where functional limitations preclude the ability to safely achieve current job demands that are at a medium to high level (not clerical/sedentary work). Chapter 5 of the ACOEM states that a clinician should specify what a patient is currently able and unable to do. Often this can be ascertained from the history, from questions about activities, and then extrapolating based on other patients with similar conditions. If unable to do this, then under some circumstances, this can be done through an FCE. The Official Disability Guidelines state that an FCE should be considered if a patient has undergone prior unsuccessful return to work attempts. They do note that an FCE is more likely to be successful if the worker is actively participating in determining the suitability of a particular job. They also note that the patient should be close to maximum medical improvement. Based on the records presented, the claimant was temporarily totally disabled. The record further defined existing impairments in her activities-of-daily living. Therefore, functional capacity has been defined. There is no documentation of the need for a work-hardening program. Also, there are no documented failed return-to-work attempts. Therefore, there is no documented medical necessity for a Functional Capacity Examination. Give the above the request is not medically necessary.

PHYSIOTHERAPY (2) TIMES A WEEK FOR (6) WEEKS FOR THE LUMBAR SPINE AND BILATERAL WRIST: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines, recommends physical therapy with fading of treatment frequency associated with "... active therapies at home as an extension of the treatment process in order to maintain improvement levels." Specifically, for myalgia and myositis, 9-10 visits over 8 weeks. For neuralgia, neuritis, and radiculitis, 8-10 visits over 4 weeks. The Official Disability Guidelines (ODG) states that for lumbar sprains/strains and disc disease, 10 visits over 8 weeks is recommended. For lumbar radiculopathy, 10-12 visits over 8 weeks. The ODG states that for wrist strain and pain, 9 visits over 8 weeks are recommended. In this case, the total number of visits requested exceeds the recommendations as noted above. Likewise, this does not allow for fading of treatment frequency and there is no mention of associated home exercises. Therefore, the record does not

document the medical necessity for physical therapy; give the above the request is not medically necessary.

ACUPUNCTURE (1) TIME A WEEK FOR (6) WEEKS FOR THE LUMBAR SPINE AND BILATERAL WRIST: Overturned

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The Acupuncture Medical Treatment Guidelines states that acupuncture is used as an option when pain medication is reduced or not tolerated, or as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It further states that 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. It is noted that acupuncture treatments may be extended if functional improvement is documented. The non-certification was based upon lack of documentation of objective abnormalities and stated functional improvement goals. However, the claimant does have documented lumbar disc disease. The evaluation notes that the recommended treatment was to relieve the patient from the effects of her injury. Function has been primarily limited by pain. The request is within the Guidelines for acupuncture therapy. Therefore, there is documented medical necessity for acupuncture. Given the above the request is medically necessary.

INTERFERENTIAL UNIT- RENT FOR 12 MONTHS: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308, Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS)/Transcutaneous Electrotherapy Page(s): 54, 114-120.

Decision rationale: Interferential Current Stimulation (IF) therapy is a type of transcutaneous electrotherapy, similar to TENS, but with different electrical specifications. The Chronic Pain Medical Treatment Guidelines states that TENS is not recommended for the back. For other conditions, a one month trial of transcutaneous therapy is considered. Specifically, Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. While studies are mixed as its effectiveness, the Guidelines note that if used, the following patient selection criteria should be used: If these criteria are met, then a one-month trial may be appropriate. A jacket should not be authorized for a one-month trial. In this case, the ICS unit is being requested for a type of pain not indicated for treatment. Transcutaneous electrotherapy is not recommended for the low back. Also, the multiple criteria noted above (documentation of duration of pain, trial plan, and goal plan) have not been met. Last, a one-month rather than twelve-month trial should

be attempted. Therefore, there is no documented medical necessity for an Interferential Current Stimulation Unit (ICS) unit. Give the above the request is not medically necessary.

NEUROSTIMULATOR TENS/EMS ATTACHMENT- RENT FOR 12 MONTHS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114-120.

Decision rationale: A Neuromuscular Stimulator is a type of transcutaneous electrotherapy that includes TENS, but also with Muscular Electrical Stimulation (MES). The Chronic Pain Medical Treatment Guidelines, states that Transcutaneous Electrical Nerve Stimulation (TENS) is not recommended for the back. For other conditions, a one month trial of transcutaneous therapy is considered appropriate if used as an adjunct to an evidence-based program of functional restoration. In this case, the multiple criteria noted above (documentation of duration of pain, trial plan, and goal plan) have not been met. The Guidelines state that a one-month rather than twelve-month trial should be attempted. Additionally, not all its modalities are recommended for the back. Therefore, there is no documented medical necessity for a TENS/EMS unit. As such the request is not medically necessary.