

Case Number:	CM14-0159809		
Date Assigned:	10/03/2014	Date of Injury:	10/02/2001
Decision Date:	10/30/2014	UR Denial Date:	09/24/2014
Priority:	Standard	Application Received:	09/29/2014

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 and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 66 year old female who sustained an industrial injury on 10/02/2001. Surgical history includes right TKA 2009, carpal tunnel surgery, right ankle surgery, and shoulder surgery. According to the 8/20/2014 medical report, right knee x-rays demonstrate well fixed, well aligned total knee arthroplasty; no evidence of loosening; mild reactive osteophyte at the inferior aspect of the patella, but does not appear to be clinically symptomatic and is not impinging on flexion. The Doctor's First Report dated 9/16/2014 describes the patient complains of constant, moderate to occasionally severe pain in the neck right = left. Pain radiates to the occipital area of the head. She complains of numbness and tingling in the neck. She complains of weakness of the bilateral hands. She complain of occipital headaches related to the neck pain. She complains of frequent mild to occasionally moderate pain in the shoulders, numbness and tingling in the shoulders, weakness and decreased ROM of the left shoulder. She complains of low back pain that occasionally radiates to the left thigh to left lateral leg, numbness and tingling in the low back. She complains of weakness on the bilateral lower extremities, urgencies, pain/symptoms in the left hid region when lying on it, pain and weakness in the right knee. She reports acid reflux controlled with medications. She complains of psychological complaints such as depression and sleep complaints. Physical examination documents the left shoulder is slightly higher, mild right antalgic gait, neck and head shift to the right, tenderness along the cervical spine right = left, upper trapezius left greater than right and mild tenderness along the paravertebral muscles right = left. Cervical compression is positive right = left. There are well healed arthroscopic scars on the left shoulder, 4 cm vertical scar on the anterior AC joint area. Positive Tinel's at left wrist. Tenderness along right SI joints R = L. Pain in lumbar pain with tiptoe walk. Positive SLR bilaterally, R greater than L. Supine Laseques is positive at 30 degrees on the left at 25 degrees. Tenderness along the left trochanter but no pain to rolling of hips. There

is 7 degrees valgus on bilateral knees. There is a mild increase in temperature along the lateral joint line of the right knee. There is well-healed incision on the midline of the right knee. There is ill-defined soft tissue mass on the right leg proximal third medial aspect. There are mild varicose veins on right leg. Patellar grinding is 1+ on the right knee and 2+ on the left. Baker's cyst moderately positive in the left knee. Diagnoses are cervical spine sprain/strain; status post left shoulder arthroscopy surgery with persistent pain and weakness; lumbar spine sprain/strain with bilateral sciatica; left hip trochanteric bursitis; status post right total knee replacement with persistent pain; GERD controlled with medications. Work status is she is on social security disability. Requested are FCE, initial trial of PT to CS, LS, left shoulder and left trochanter, and IF unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Baseline Functional Capacity Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Fitness for Duty Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional capacity evaluation (FCE)

Decision rationale: Consider using a functional capacity evaluation when necessary to translate medical impairment into functional limitations and determine work capability."ODG: Functional Capacity Evaluation - Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. Not recommend routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally. Consider an FCE if 1) Case management is hampered by complex issues such as: - Prior unsuccessful RTW attempts. - Conflicting medical reporting on precautions and/or fitness for modified job. - Injuries that require detailed exploration of a worker's abilities. 2) Timing is appropriate: - Close or at MMI/all key medical reports secured. - Additional/secondary conditions clarified. Do not proceed with an FCE if - The sole purpose is to determine a worker's effort or compliance. - The worker has returned to work and an ergonomic assessment has not been arranged. The purpose and medical necessity of an FCE is not clear in this case. The medical records do not reveal any recent failed return to work attempts, document conflicting medical reporting on precautions or fitness to perform modified job duties, or indicate she has injuries that required detailed exploration of her abilities. There is no indication that this patient is interested in returning to work. In addition, it is reasonable that functional ability can be assessed based on the routine evaluations her treating physician. She has been rendered P&S by prior providers. The medical records do not reflect that this patient is considered at/near MMI at this time. Furthermore, there is no evidence that the patient is a candidate for a work hardening program. The medical necessity of an objective FCE has not been established. The request is not medically necessary.

Physical Therapy left shoulder: 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.

Decision rationale: According to the CA MTUS, Physical Medicine Guidelines -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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels.Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine.Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks the patient is several years post the date of industrial injury. The medical records do not provide a through treatment history regarding the left shoulder. The number of physical therapy sessions completed to date, when she last attended therapy, and her response to the previously rendered care has not been provided. Furthermore, the documented complaints and objective findings do not establish that the patient presents with a new injury or significant exacerbation or flare-up beyond self-care, to warrant a return to attended care. Given the remote injury, it is reasonable that the patient should be well versed in an independent home exercise program. The guidelines state patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There is no mention of utilization of a self-directed home exercise program as would be recommended and supported by the guidelines. In the absence of clear evidence of a significant exacerbation, flare-up or re-injury with loss of function unresponsive to self-care measures, the medical necessity of the request for PT has not been established. The request is not medically necessary.

IF Unit & Supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119.

Decision rationale: According to the guidelines, insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. The medical records do not establish the patient has failed standard treatment measures. According to the CA MTUS guidelines, interferential current stimulation is not generally recommended as there is no evidence supporting or establishing efficacy in this form of treatment. The medical records do not establish this patient has any of the criteria such as history of substance abuse or significant postoperative pain, or ineffective pain control with medications due to significant side effects. The medical do not establish that

purchase of the requested IF unit and supplies is appropriate or medically necessary for the management of this patient's diagnoses. The request is not medically necessary.