

Case Number:	CM14-0037643		
Date Assigned:	06/25/2014	Date of Injury:	07/10/2013
Decision Date:	07/29/2014	UR Denial Date:	03/17/2014
Priority:	Standard	Application Received:	03/28/2014

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 Interventional Spine 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 46 year old female with date of injury 7/10/13. The treating physician report dated 2/6/14 indicates that the patient presents with pain affecting the mid/upper back 5/10 (unchanged), bilateral shoulders/arms (decreased from 6/10 to 3/10) and lower back (increased to 8/10 from 5/10) that radiates in the pattern of bilateral L4 and L5 dermatomes. The treating physician notes that the patient states acupuncture helps decrease pain, the EMG/NCV of the lumbar spine is positive for radiculopathy, she is pending extracorporeal shockwave therapy of the lumbar spine and the patient does not like to take medicine in fear of liver damage. The current diagnoses are: 1.Thoracic musculoligamentous s/s2.L4-5 disc protrusions with annular tear with lumbar intervertebral foramina encroach, per medical records.3.Bilateral shoulders s/s4.Depression, situational5.Sleep disturbance secondary to painThe utilization review report dated 3/17/14 denied the request for functional capacity evaluation, range of motion testing, muscle testing, acupuncture 12 visits and pain management consultation based on lack of medical documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

FCE (functional capacity evaluation): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 137-138.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page(s) 137-138.

Decision rationale: The patient presents with chronic cervical, thoracic and lumbar pain with bilateral shoulder, arm and leg pain. The current request is for a Functional Capacity Evaluation (FCE). Review of the 265 pages of medical records provided, revealed that the treating physician's initial consultation report dated 11/25/13 states, "To aid my diagnosis further, the following studies are being requested: EMG/NCV bilateral lower extremities, Functional Capacity Evaluation, Urine toxicology testing." The treating physician also documents that the patient is totally temporarily disabled from 11/25/13 to 1/2/14. The MTUS Guidelines do not discuss functional capacity evaluations. ACOEM chapter 7, was not adopted into MTUS, but would be the next highest-ranked standard according to LC4610.5(2)(B). ACOEM does not appear to support the functional capacity evaluations and states: "Functional capacity evaluations may establish physical abilities, and also facilitate the examinee/employer relationship for return to work. However, FCEs can be deliberately simplified evaluations based on multiple assumptions and subjective factors, which are not always apparent to their requesting physician. There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace; an FCE reflects what an individual can do on a single day, at a particular time, under controlled circumstances, that provide an indication of that individual's abilities. As with any behavior, an individual's performance on an FCE is probably influenced by multiple nonmedical factors other than physical impairments. For these reasons, it is problematic to rely solely upon the FCE results for determination of current work capability and restrictions." The treater in this case has requested an FCE to aid in the patient's diagnosis. The ACOEM Guidelines do not support an FCE to aid in diagnosis. Recommendation is for denial.

ROM (range of motion) 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/ Flexibility.

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

Decision rationale: The patient presents with chronic cervical, thoracic and lumbar pain with bilateral shoulder, arm and leg pain. The current request is for Range of Motion (ROM) testing. In reviewing the reports provided there was no specific request for Range of Motion testing. The treating physician's initial report dated 11/25/13 under physical examination states, "Cervical flexion 50/50, extension 60/60, RLF 45/45, LLF 45/45, right rotation 80/80 and left rotation 80/80. Thoracic spine ranges of motion, flexion 50/50, RR 30/30, LR 30/30. Lumbosacral spine ranges of motion, flexion 36/60, extension 18/25, RLF 16/25, LLF 19/25. All range of motion measurements of the lumbar spine were performed using Acumar Computerized Dual Inclinometers with automatic subtraction." The MTUS Guidelines do not address ROM testing. The ODG lumbar chapter for ROM (Flexibility) does not recommend computerized measures of the lumbar spine which can be performed using an inclinometer which is reproducible, simple,

practical and inexpensive. There is no documentation in the reports provided to indicate the medical necessity for a separate procedure for ROM testing outside of the standard routine part of a physical examination. The request is not medically necessary.

Muscle testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Policy: Quantitative Muscle Testing Devices.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: AETNA Policy online, Quantitative Muscle Testing Devices.

Decision rationale: The patient presents with chronic cervical, thoracic and lumbar pain with bilateral shoulder, arm and leg pain. The current request is for Muscle Testing. In reviewing the treating physician reports provided there is no request found for muscle testing. The initial consultation report dated 11/25/13 states, "Upper Extremities Motor Strength Testing for shoulders flexion, abduction, extension, adduction, internal rotation and external rotation on the right are 4/5 and 5/5 on the left. The treater in this case has performed standard muscle testing as part of the physical examination. The MTUS and ODG Guidelines do not address muscle testing. Review of the AETNA Policy guidelines states, "Aetna considers the use of quantitative muscle testing devices experimental and investigational when used for muscle testing because there is insufficient evidence that use of these devices improves the assessment of muscle strength over standard manual strength testing such that clinical outcomes are improved." In this case there is no medical rationale provided for the current request of a separate procedure of Muscle Testing and AETNA Policy does not support quantitative muscle testing. The request is not medically necessary.

Acupuncture x 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The patient presents with chronic cervical, thoracic and lumbar pain with bilateral shoulder, arm and leg pain. The current request is for Acupuncture x 12. The treating physician requested on 11/25/13 acupuncture of the thoracic spine, lumbar spine and bilateral shoulders 2x6. On 1/10/14 there is an acupuncture follow up evaluation that states in the progress summary, "Temporary pain relief." The acupuncturist recommended continued care 2x4. The treating physician on 1/2/14 states, "The patient is prescribed acupuncture therapy to the lumbar spine 2x4 weeks. She has completed 8 sessions of acupuncture therapy." There is no documentation of any functional improvement with the 8 sessions of acupuncture. On 2/6/14 the treating physician states, "The patient states that acupuncture therapy helps to decrease her pain and tenderness. The patient is prescribed acupuncture therapy to the lumbar spine 2x6." Review

of the Acupuncture Medical Treatment Guidelines (AMTG) supports acupuncture with frequency and duration as follows, "Time to produce functional improvement: 3 to 6 treatments. Frequency: 1 to 3 times per week. Optimum duration: 1 to 2 months." The treater in this case has continued to prescribe continued acupuncture therapy with no documentation of functional improvement. MTUS 9792.2(f) "Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment. The treater in this case has not documented that acupuncture treatment provides functional improvement and the continued prescription of treatment goes beyond the 1-2 months recommended in the AMTG. The request is not medically necessary.

Pain management consultation: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page(s) 127.

Decision rationale: The patient presents with chronic cervical, thoracic and lumbar pain with bilateral shoulder, arm and leg pain. The current request is for a Pain Management Consultation. The treating physician report dated 2/6/14 states, "She is referred for a consultation with a pain management specialist regarding her lumbar spine." The ACOEM guidelines on page 127 state that specialty referral is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. The current request is supported by the ACOEM guidelines for specialty referral. The treating physician feels that additional expertise in pain management may be required in this patient. The request is medically necessary.