

Case Number:	CM14-0065814		
Date Assigned:	07/11/2014	Date of Injury:	05/07/2011
Decision Date:	09/24/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	05/09/2014

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 Neuromuscular Medicine and is licensed to practice in Maryland. 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 52 year old female with a work injury dated 5/7/11. The diagnoses include cervical disc displacement without myelopathy, internal derangement of the shoulder, and thoracic sprain/strain. Under consideration is a request for functional restoration program, dental treatment and a 30 day rental of an H-wave unit. There is a primary treating physician report dated 2/5/14 which states that the patient complains of neck pain, which is constant and severe and radiates into bilateral upper extremities with left greater than right with numbness and tingling to the hands. She complains of weakness and dropping of items constantly. The headaches are associated with her neck pain. She has ringing in the ears. There is left shoulder pain which is dull and achy becoming very sharp and burning with increased activities. Her upper back and mid back pain cause muscle spasms. There is sleep deprivation related to pain and stress causing daytime tiredness. The grinding of the teeth causing jaw pain. Similarly she has stress, anxiety and depression. related to pain, and stomach pain with vomiting and diarrhea related to pain and stress. On exam she has decreased cervical range of motion with positive cervical compression testing. Her bilateral upper extremity sensation and reflexes were within normal range. There is decreased left shoulder range of motion and strength. There are positive bilateral Phalen, Tinel and Finkelstein's signs. There are requests for acupuncture, PT, dental evaluation. There is a 3/19/14 PR-2 report which is difficult to read and handwritten. The patient complains of tooth pain, cervical and upper extremity pain, stress, frustration and chronic pain. She is afraid to perform activities and afraid to be touched in PT. The plan included H wave, dental treatment, FRP.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Restoration Program: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chronic Pain Treatment Guidelines Functional Restoration Programs Page(s): 49 of 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the general use of multidisciplinary pain management programs Page(s): 31-32.

Decision rationale: A Functional Restoration Program is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that an adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement. The guidelines also state that the patient should exhibit motivation to change. Furthermore, treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. The documentation does not indicate the patient has motivation to change. The documentation does not indicate that an evaluation for this program has been made. The guidelines do not recommend an entire functional restoration program at one time but rather a 2 week trial with demonstrated efficacy. The request as written does not have a time limited duration. The request for a Functional Restoration Program (FRP) is not medically necessary.

H-Wave Unit x 30 day trial Cervical/Thoracic Spine, Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT) Page(s): 117-118 of 127.

Decision rationale: H-Wave Unit x30 day trial Cervical/Thoracic Spine, Left Shoulder is not medically necessary per MTUS Chronic Pain Medical Treatment Guidelines. The guidelines states that the H wave is not recommended as an isolated intervention, but a one-month home-based trial of H Wave stimulation may be considered as a noninvasive conservative option for chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). The documentation does not indicate a plan for functional restoration. The documentation indicates that the patient is afraid to perform therapy. There is no documentation that the patient has failed TENS. The request for H-Wave Unit x 30 day trial Cervical/Thoracic Spine, Left Shoulder is not medically necessary.