

Case Number:	CM14-0172140		
Date Assigned:	10/23/2014	Date of Injury:	05/04/2013
Decision Date:	03/24/2015	UR Denial Date:	10/10/2014
Priority:	Standard	Application Received:	10/17/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: North Carolina
 Certification(s)/Specialty: Family Practice

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 51-year-old with a reported date of injury) 5/14/2013. The patient has the diagnoses of medication induced gastritis, cervical spine strain/sprain with myospasm, lumbar spine strain/sprain, bilateral lateral epicondylitis, bilateral elbow sprain/strain, status post right wrist open reduction and internal fixation and removal of hardware, right wrist pain, left knee sprain/strain and right wrist tear of the ulnar attachment of the triangular fibrocartilage and tenosynovitis. Per the most recent progress notes provided for review from the primary treating physician dated 09/19/2014, the patient had complaints of continued and stable pain in the cervical spine, right shoulder, right wrist, bilateral elbows, lumbar spine and left knee. The physical exam noted tenderness over the cervical and lumbar paraspinal muscles, mild decreased range of motion in the shoulders, tenderness over the bilateral medial and lateral epicondyle, decreased range of motion in the right wrist with tenderness over the surgical scar and the left knee has tenderness around the medial and lateral joint lines. Treatment plan recommendations included request for a functional restoration program, acupuncture, range of motion and muscle strength testing, TENS unit, hot/cold unit, EMG/NCV of the bilateral upper extremities and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right wrist/left knee functional restoration program 2x6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 49.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines functional restoration program Page(s): 49.

Decision rationale: The California chronic pain medical treatment guidelines section on functional restoration programs states: Recommended, although research is still ongoing as to how to most appropriately screen for inclusion in these programs. Functional restoration programs (FRPs), a type of treatment included in the category of interdisciplinary pain programs (see Chronic pain programs), were originally developed by Mayer and Gatchel. FRPs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. Long-term evidence suggests that the benefit of these programs diminishes over time, but still remains positive when compared to cohorts that did not receive an intensive program. (Bendix, 1998) A Cochrane review suggests that there is strong evidence that intensive multidisciplinary rehabilitation with functional restoration reduces pain and improves function of patients with low back pain. The evidence is contradictory when evaluating the programs in terms of vocational outcomes. (Guzman 2001) It must be noted that all studies used for the Cochrane review excluded individuals with extensive radiculopathy, and several of the studies excluded patients who were receiving a pension, limiting the generalizability of the above results. Studies published after the Cochrane review also indicate that intensive programs show greater effectiveness, in particular in terms of return to work, than less intensive treatment. (Airaksinen, 2006) There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. (Karjalainen, 2003) Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. For general information see Chronic pain programs. While functional restoration programs are recommended per the California MTUS, the length of time is for 2 weeks unless there is documentation of demonstrated efficacy by subjective and objective gains. The request is for 6 weeks. This is in excess of the recommendations and thus is not certified.

Right wrist acupuncture 2x6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines acupuncture Page(s): 13.

Decision rationale: The California chronic pain medical treatment guidelines section on acupuncture states: Frequency and duration of acupuncture with electrical stimulation may be performed as follows: 1. Time to produce functional improvement 3-6 treatments 2. Frequency: 1-3 times per week 3. Optimum duration is 1-2 months 4. Treatments may be extended if functional improvement is documented. The request for acupuncture is for a total of 12 sessions. This is in excess of the recommendations. The patient must demonstrate functional improvement in 3-6 treatments for more sessions to be certified. Therefore the request is in excess of the recommended initial treatment sessions and not certified.

Left knee acupuncture 2x6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines acupuncture Page(s): 13.

Decision rationale: The California chronic pain medical treatment guidelines section on acupuncture states: 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. Frequency and duration of acupuncture with electrical stimulation may be performed as follows: 5. Time to produce functional improvement 3-6 treatments 6. Frequency: 1-3 times per week 7. Optimum duration is 1-2 months 8. Treatments may be extended if functional improvement is documented The request for acupuncture is for a total of 12 sessions. This is in excess of the recommendations. The patient must demonstrate functional improvement in 3-6 treatments for more sessions to be certified. Therefore the request is in excess of the recommended initial treatment sessions and not certified.

Soma 350mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 65.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-65.

Decision rationale: The California chronic pain medical treatment guidelines section on acupuncture states: Frequency and duration of acupuncture with electrical stimulation may be performed as follows: 1. Time to produce functional improvement 3-6 treatments 2. Frequency: 1-3 times per week 3. Optimum duration is 1-2 months 4. Treatments may be extended if functional improvement is documented. The request for acupuncture is for a total of 12 sessions.

This is in excess of the recommendations. The patient must demonstrate functional improvement in 3-6 treatments for more sessions to be certified. Therefore the request is in excess of the recommended initial treatment sessions and not certified.

TENS for right wrist and left knee purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114.

Decision rationale: The California chronic pain medical treatment guidelines section on transcutaneous electrical nerve stimulation states: TENS, chronic pain (transcutaneous electrical nerve stimulation) Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. (Carroll-Cochrane, 2001) Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. One problem with current studies is that many only evaluated single-dose treatment, which may not reflect the use of this modality in a clinical setting. Other problems include statistical methodology, small sample size, influence of placebo effect, and difficulty comparing the different outcomes that were measured. This treatment option is recommended as an adjunct to a program of evidence based functional restoration. However, it is recommended for a one-month trial to document subjective and objective gains from the treatment. This request is for purchase and not a one-month trial. Therefore criteria have not been met and the request is not certified.

Hot/cold therapy for right wrist and left knee purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 13 Knee Complaints Page(s): 264, 338. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

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

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The ACOEM does recommend the at home local application of cold packs the first few days after injury and thereafter the application of heat packs. The Official Disability Guidelines section on cryotherapy states: Recommended as an option after surgery but not for nonsurgical treatment. There is no documentation on why at home cold and hot packs would not

suffice for the treatment of this patient. The patient is not acutely post surgery there is also no indication for DVT prophylaxis. Therefore the request is not certified.

Right upper extremity range of motion and muscle strength testing performed on 9/19/14:
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)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 277-303.

Decision rationale: The California MTUS does not specifically address this request. The ACOEM does not address flexibility and strength testing specifically in the shoulder, forearm or wrist chapter. However the low back chapter states flexibility testing should be simply part of the routine physical exam. There is no indication why this would not be included in the routine physical examination of the right upper extremity and why any specialized range of motion and, muscle strength testing would be necessary beyond the physical exam. Therefore the request is not certified.