

Case Number:	CM14-0196136		
Date Assigned:	12/04/2014	Date of Injury:	12/13/2013
Decision Date:	01/22/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	11/24/2014

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 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 50 year old male with an injury date on 12/13/2013. Based on the 10/13/2014 hand written progress report provided by the treating physician, the diagnoses are bilateral pain, Anxiety and depression, lumbar spine back pain, bilateral UE pain, and left shoulder pain. According to this report, the patient complains of left shoulder pain and low back pain. Objective findings indicate left shoulder range of motion is decreased; "cannot fully extend left shoulder above arm." The 09/19/2014 report indicates the patient complains of constant moderate sharp low back pain and left shoulder pain. Tenderness to palpation is noted at the lumbar paravertebral muscle, spinous processes, left acromioclavicular joint and anterior shoulder. Cross Arm Test and Reverse Mill's test are positive. The treatment plan is continue to request for physical therapy and acupuncture (1x6wek), RTW/FCE, and LINT for the lumbar spine. The patient's work status is "no work." There were no other significant findings noted on this report. The utilization review denied the request for (1)Physical therapy once a week for six weeks, (2) RTW / FCE, (3) Acupuncture, once a week for six weeks, (4)Urine toxicology, once every six weeks, (5)LINT, once weekly for six weeks on 11/18/2014 based on the MTUS/ODG guidelines. The requesting physician provided treatment reports from 09/19/2014 to 11/05/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, once weekly for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Section Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99; 8.

Decision rationale: According to the 10/13/2014 report, this patient presents with constant moderate sharp low back pain and left shoulder pain. The current request is for Physical therapy once a week for six weeks. For physical medicine, MTUS guidelines pages 98-99 state that for myalgia and myositis, 9-10 visits are recommended over 8 weeks. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Review of the available records shows no therapy reports and there is no discussion regarding the patient's progress. If the patient did not have any recent therapy, a short course of therapy may be reasonable for declined function or a flare-up of symptoms. However, there is no documentation of flare-up or a new injury to warrant formalized therapy. The treating physical does not discuss the patient's treatment history or the reasons for requested additional therapy. There is no discussion provided as to why the patient is not able to perform the necessary home exercises. MTUS page 8 requires that the physician provide monitoring of the patient's progress and make appropriate recommendations. The current request is not medically necessary.

RTW/FCE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 104.

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 137 Functional/Capacity Evaluation

Decision rationale: According to the 10/13/2014 report, this patient presents with constant moderate sharp low back pain and left shoulder pain. The current request is for RTW/FCE. Regarding Functional/Capacity Evaluation, ACOEM Guidelines page 137 states, "The examiner is responsible for determining whether the impairment results in functional limitations. The employer or claim administrator may request functional ability evaluations. These assessments also may be ordered by the treating or evaluating physician, if the physician feels the information from such testing is crucial...There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace. "The Utilization Review denial letter states "The medical record does not indicate that this patient is prepared to return to work and specific work activities, limitations and goals are not provided. Therefore the request for RTW/FCE is denied." In this case, the treating physician does not provide medical rationale for the request; the treatment plan simply states "RTW/FCE." The treating physician does not explain why FCE is crucial, and it is not requested by the employer or the claims administrator. The FCE does not predict the patient's actual capacity to perform in the workplace. The current request is not medically necessary.

Acupuncture, once weekly for six weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acupuncture Medical Treatment Guidelines.<http://www.dir.ca.gov/dwc/DWCPropRegs/MedicalTreatmentmen>.

Decision rationale: According to the 10/13/2014 report, this patient presents with constant moderate sharp low back pain and left shoulder pain. The current request is for Acupuncture, once a week for six weeks. For acupuncture, MTUS Guidelines page 8 recommends acupuncture for pain suffering and restoration of function. Recommended frequency and duration is 3 to 6 treatments to produce functional improvement, with optimal duration of 1 to 2 months. The Utilization Review denial letter states "A previous acupuncture request for six visits was approved on 9/19/14. The results of this treatment are not provided for review. Continuation of acupuncture is not clinically indicated without proof of improvement." Review of provided reports do not show prior acupuncture reports. However, the 09/19/2014 report show there was a "request for Acupuncture, once a week for six weeks" and the UR alludes that "six visits was approved on 9/19/14." In this case, the patient was recently approved for 6 sessions of Acupuncture but the treating did not discuss the patient's outcome from prior acupuncture treatment. Without providing documentation of functional improvement, additional treatments are not supported by MTUS. The current request is not medically necessary.

Urine toxicology, once every six weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines UDS Drug testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter under urine drug testing

Decision rationale: According to the 10/13/2014 report, this patient presents with constant moderate sharp low back pain and left shoulder pain. The current request is for Urine toxicology, once every six weeks. Regarding UDS's, MTUS Guidelines do not specifically address how frequent UDS should be obtained for various risks of opiate users, ODG Guidelines provide clearer recommendation. It recommends once yearly urine screen following initial screening with the first 6 months for management of chronic opiate use in low risk patient. In this case, the available medical records do not indicate the patient is on opiate therapy. ODG guidelines support yearly UDS's for a low risk opiate user. The treating physician did not why UDS is needed once every six weeks. There is no discussion regarding this patient being at risk for any aberrant behaviors. Therefore, the current request is not medically necessary.

Lint, once weekly for six weeks: Upheld

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 Official Disability Guidelines (ODG) Low back chapter under Hyperstimulation analgesia

Decision rationale: According to the 10/13/2014 report, this patient presents with constant moderate sharp low back pain and left shoulder pain. The current request is for LINT, once weekly for six weeks. Regarding Hyper stimulation analgesia, ODG guidelines states "Not recommended until there are higher quality studies." In this case, the requested Neurostimulation Therapy is not supported by the guidelines; therefore, the current request is not medically necessary.