

Case Number:	CM15-0004950		
Date Assigned:	02/13/2015	Date of Injury:	12/10/2013
Decision Date:	04/07/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/09/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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 injured worker is a 35 year old male, who sustained an industrial injury on December 10, 2013. He has reported injury to multiple body parts. The diagnoses have included cervical myospasm, cervical sprain/strain, lumbar sprain/strain, bilateral shoulder sprain/strain, bilateral wrist sprain/strain, and bilateral foot bursitis. Treatment to date has included physical therapy, chiropractic therapy, acupuncture, and medications. Currently, the IW complains of neck pain, low back pain with stiffness, bilateral shoulder pain with heaviness, bilateral wrist pain with stiffness, numbness and tingling, and bilateral foot pain with stiffness. Physical findings are noted to be a decreased range of motion of the neck, lumbar spine with positive Kemp's test, shoulders positive for pain in cross arm testing. On December 22, 2014, Utilization Review non-certified functional capacity evaluation, and physical therapy one time weekly for six weeks for the cervical spine, and physical therapy one time weekly for six weeks for the lumbar spine, and physical therapy one time weekly for six weeks for bilateral shoulders, and physical therapy one time weekly for six weeks for bilateral wrists and feet, and VSNCT testing for bilateral shoulders, and acupuncture one time weekly for six weeks for bilateral wrists and feet, and chiropractic one time weekly for six weeks for the cervical spine, and chiropractic one time weekly for six weeks for the lumbar spine, and chiropractic one time weekly for six weeks for bilateral shoulders, and chiropractic one time weekly for six weeks for bilateral wrists and feet, and neurosurgeon/orthopedic consultation for bilateral shoulders and wrists, and lumbar traction system rental, and cervical traction system rental, and compound medications: Capsaicin 0.025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2%, quantity #180 grams,

and Gabapentin 15%, amitriptyline 4%, Dextromethorphan 10%, quantity #180 grams, and acupuncture one time weekly for six weeks for the cervical spine, and acupuncture one time weekly for six weeks for the lumbar spine, and acupuncture one time weekly for six weeks for bilateral shoulders. The MTUS, ACOEM, ODG, and non-MTUS guidelines were cited. On December 31, 2014, the injured worker submitted an application for IMR for review of functional capacity evaluation, and physical therapy one time weekly for six weeks for the cervical spine, and physical therapy one time weekly for six weeks for the lumbar spine, and physical therapy one time weekly for six weeks for bilateral shoulders, and physical therapy one time weekly for six weeks for bilateral wrists and feet, and VSNCT testing for bilateral shoulders, and acupuncture one time weekly for six weeks for bilateral wrists and feet, and chiropractic one time weekly for six weeks for the cervical spine, and chiropractic one time weekly for six weeks for the lumbar spine, and chiropractic one time weekly for six weeks for bilateral shoulders, and chiropractic one time weekly for six weeks for bilateral wrists and feet, and neurosurgeon/orthopedic consultation for bilateral shoulders and wrists, and lumbar traction system rental, and cervical traction system rental, and compound medications: Capsaicin 0.025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2%, quantity #180 grams, and Gabapentin 15%, amitriptyline 4%, Dextromethorphan 10%, quantity #180 grams, and acupuncture one time weekly for six weeks for the cervical spine, and acupuncture one time weekly for six weeks for the lumbar spine, and acupuncture one time weekly for six weeks for bilateral shoulders.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional capacity evaluation (FCE): 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 Chronic Pain Treatment Guidelines Functional Capacity Evaluation Page(s): 48.

Decision rationale: The CA MTUS states that a functional capacity evaluation (FCE) is recommended under certain specific circumstances. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. It should include work functions and or activities of daily living, self-report of disability, objective measures of the patient's functional performance and physical impairments. The guidelines necessitate documentation indicating case management is hampered by complex issues (prior unsuccessful return to work attempts, conflicting medical reports on precautions and/or fitness for modified job), injuries that require detailed exploration of a worker's abilities, and clarification of all additional/secondary conditions in order to recommend an FCE. In this case, there is no documentation that any of the above conditions that are required to complete an FCE, are present. There are no specific indications for an FCE. Medical necessity for the requested service is not established. The requested service is not medically necessary.

Physical therapy one time six for the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of neck pain. ODG recommends that for most patients with more severe and sub-acute neck pain conditions up to 10 visits are indicated as long as functional improvement and program progression are documented. 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. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, there is no documentation of the number of previous PT treatments, to determine if the treatments completed have already exceeded the guideline recommendation. In addition, there is no documentation of objective improvement with previous treatment. Medical necessity for the requested service is not established. The requested service is not medically necessary.

Physical therapy one times six for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter.

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

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Recommendations state that for most patients with more severe and sub-acute low back pain conditions, 8 to 12 visits over a period of 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. 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. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, there is no documentation of the number of previous PT treatments, to determine if the treatments completed have already exceeded the guideline recommendations. In addition, there is no documentation of objective improvement with

previous treatment. Medical necessity for the requested physical therapy for the lumbar spine (1x6) has not been established. The requested service is not medically necessary.

Physical therapy one times six for the bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines, <http://www.odg-twc.com/preface.htm> Physical therapy Guidelines and Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of shoulder pain. ODG recommends that for most patients with more severe and sub-acute shoulder pain conditions up to 10 visits are indicated as long as functional improvement and program progression are documented. 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. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, there is no documentation of the number of previous PT treatments, to determine if the treatments completed have already exceeded the guideline recommendations. In addition, there is no documentation of objective improvement with previous treatment. Medical necessity for the requested PT for bilateral shoulders (1x6) has not been established. The requested service is not medically necessary.

Physical therapy one times six for the bilateral wrists and feet: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines <http://www.odg-twc.com/preface.htm#physicalTherapyGuidelines>, Forearm, Wrist, and Hand Chapter, and Ankle and Foot Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand Chapter Ankle and Foot Chapter.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain involving the wrist and feet. Recommendations per ODG state that for most patients with more severe and sub-acute pain conditions up to 9 visits are indicated as long as functional improvement and program progression are documented. 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. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, there is no documentation of the number of previous PT treatments, to determine if the treatments completed have already exceeded the guideline recommendations. In addition, there is no documentation of objective improvement with previous treatment. Medical necessity for the requested PT for bilateral wrists and feet has not been established. The requested service is not medically necessary.

VSNCT testing for the bilateral shoulders: 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, Neck and Upper Back Chapter.

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

Decision rationale: The ODG does not recommend Voltage Actuated Sensory Nerve Conduction Testing (VSNCT). There are no clinical studies demonstrating that quantitative tests of sensation improve the management and clinical outcomes of patients over standardized qualitative methods of sensory testing. This test is different and distinct from the assessment of nerve conduction velocity, amplitude and latency, but its ability to diagnose sensory neuropathies or radiculopathies is not reasonable or necessary. Evidence based guidelines do not consistently support the use of VSNCT in the management of shoulder conditions. Medical necessity for the requested VSNCT testing for the bilateral shoulders has not been established. The requested service is not medically necessary.

Acupuncture one times six for the bilateral wrists and feet: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to the Acupuncture Medical Treatment Guidelines, 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 recovery. The treatment guidelines support acupuncture treatment to begin as an initial treatment of 3-6 sessions over no more than two weeks. If functional improvement is documented, as defined by the guidelines further treatment will be considered. In this case, there is documentation of previous acupuncture visits, however, there is no documentation of the previous number of acupuncture treatments completed or documentation of objective improvement with previous treatments. In addition, given the associated requests for physical therapy and chiropractic therapy, there is no documentation of a rationale for providing concurrent physical modalities. Medical necessity for

acupuncture for bilateral wrists and feet (1x6) has not been established. The requested service is not medically necessary.

Chiropractic one times six for the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Manual Therapy.

Decision rationale: Per the ACOEM Guideline citation above, Chiropractic manipulation is a treatment option during the acute phase of injury, and manipulation should not be continued for more than a month, particularly when there is not a good response to treatment. The ODG states that cervical manipulation may be an option for patients with occupationally related neck pain or cervicogenic headache. ODG recommends up to 18 total chiropractic and massage visits over 6-8 weeks for cervical and thoracic injuries with evidence of functional improvement after a 6 visit initial trial. In this case, there is documentation of previous chiropractic visits, functional deficits, and functional goals. There is no documentation of the previous number of chiropractic treatments to determine if the completed number has already exceeded the guidelines. In addition, there are associated requests for physical therapy and acupuncture without a clear documentation of a rationale for providing concurrent physical modalities. Medical necessity for the requested chiropractic therapy for the cervical spine (1x6) has not been established. The requested service is not medically necessary.

Chiropractic one time six for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Page(s): 58.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299.

Decision rationale: Per the ACOEM Guideline citation above, Chiropractic manipulation is a treatment option during the acute phase of back pain without radiculopathy and manipulation should not be continued for more than a month, particularly when there is not a good response to treatment. Per the MTUS, chronic pain section citation listed above, a trial of 6 visits of manual therapy and manipulation may be provided over 2 weeks, with any further manual therapy contingent upon functional improvement. Evidence based guidelines support up to 18 visits over 6-8 weeks. In this case there is documentation of previous chiropractic visits, functional deficits, and functional goals. There is no documentation of the previous number of chiropractic treatments to determine if the completed number has already exceeded the guidelines. In addition, there are associated requests for physical therapy and acupuncture without a clear documentation of a rationale for providing concurrent physical modalities. Medical necessity for

the requested Per the ACOEM Guideline citation above, Chiropractic manipulation is a treatment option during the acute phase of injury, and manipulation should not be continued for more than a month, particularly when there is not a good response to treatment. The ODG states that cervical manipulation may be an option for patients with occupationally related neck pain or cervicogenic headache. ODG recommends up to 18 total chiropractic and massage visits over 6-8 weeks for cervical and thoracic injuries with evidence of functional improvement after a 6 visit initial trial. In this case, there is documentation of previous chiropractic visits, functional deficits, and functional goals. There is no documentation of the previous number of chiropractic treatments to determine if the completed number has already exceeded the guidelines. In addition, there are associated requests for physical therapy and acupuncture without a clear documentation of a rationale for providing concurrent physical modalities. Medical necessity for the requested chiropractic therapy for the lumbar spine (1x6) has not been established. The requested service is not medically necessary.

Chiropractic one times six for the bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

Decision rationale: Per the ACOEM Guideline citation above, Chiropractic manipulation is a treatment option in the management of frozen shoulder and thoracic outlet compression. Per the MTUS, chronic pain section citation listed above, a trial of 6 visits of manual therapy and manipulation may be provided over 2 weeks, with any further manual therapy contingent upon functional improvement. Evidence based guidelines support up to 18 visits. In this case there is documentation of previous chiropractic visits, functional deficits, and functional goals. There is no documentation of the previous number of chiropractic treatments to determine if the completed number has already exceeded the guidelines. In addition, there are associated requests for physical therapy and acupuncture without a clear documentation of a rationale for providing concurrent physical modalities. Medical necessity for the requested Per the ACOEM Guideline citation above, Chiropractic manipulation is a treatment option during the acute phase of injury, and manipulation should not be continued for more than a month, particularly when there is not a good response to treatment. The ODG states that cervical manipulation may be an option for patients with occupationally related neck pain or cervicogenic headache. ODG recommends up to 18 total chiropractic and massage visits over 6-8 weeks for cervical and thoracic injuries with evidence of functional improvement after a 6 visit initial trial. In this case, there is documentation of previous chiropractic visits, functional deficits, and functional goals. There is no documentation of the previous number of chiropractic treatments to determine if the completed number has already exceeded the guidelines. In addition, there are associated requests for physical therapy and acupuncture without a clear documentation of a rationale for providing concurrent physical modalities. Medical necessity for the requested chiropractic therapy for bilateral shoulders (1x6) has not been established. The requested service is not medically necessary.

Chiropractic one times six for the bilateral wrists and feet: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 369, Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 369, Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58.

Decision rationale: The MTUS recommends against chiropractic manipulation for the knee, elbow, forearm, wrist, hand, ankle, and foot. This prescription was for the bilateral wrists and feet, which are not recommended per the MTUS. Medical necessity for the requested treatments has not been established. The requested treatments are not medically necessary.

Neurosurgeon/orthopedic consult for the bilateral shoulders and wrists: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 127.

Decision rationale: ACOEM states that consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, there is no specific rationale identifying the medical necessity of the requested Neurosurgery/Orthopedic consultations for the bilateral shoulder and wrists. There is also no documentation that diagnostic and therapeutic management has been exhausted within the present treating provider's scope of practice. Medical necessity for the requested service is not established. The requested service is not medically necessary.

Lumbar traction system (rental): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: According to ACOEM, lumbar traction has not been proven to be effective for lasting relief in treating low back pain. There is insufficient evidence to support the use of vertebral axial decompression for treating low back injuries. In this case, there is no documentation that the requested lumbar traction will be used as an adjunct to a program of

evidence-based conservative care to achieve functional restoration in the management of low back pain. In addition, there is no documentation of the proposed duration of treatment with the requested lumbar traction system (rental). Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Compounded medications: capsaicin 0.025% flurbiprofen 15% gabapentin 10% menthol 2% camphor 2%, 180 grams, and gabapentin 15%, amitriptyline 4%, dextromethorphan 10 mg 180 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical/compounded medication is: capsaicin 0.025% flurbiprofen 15% gabapentin 10% menthol 2% camphor 2%. This medication contains capsaicin, which is only recommended as an option in patients who have not responded or are intolerant to other treatments, per MTUS. In addition, there are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). There is no documentation of intolerance to other previous oral medications. The medical necessity of the requested compounded medication has not been established. The requested topical analgesic compound is not medically necessary.

Cervical traction system (rental): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Uppers Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cervical Traction, Neck and Upper Back Chapters.

Decision rationale: The ODG states that traction is recommended for patients with cervical radicular symptoms. Studies have demonstrated that home cervical traction can provide symptomatic relief in over 80% of patients with mild to moderately severe (Grade 3) cervical spinal syndrome with radicular symptoms. ODG recommends home cervical auto-traction (patient-controlled), but not powered traction devices. It is recommended that cervical traction

be used in conjunction with a home exercise program. In this case, there is no documentation of mild to moderately severe (Grade 3) cervical spinal syndrome with radicular symptoms. There is no documentation that the requested cervical traction is being used in conjunction with a home exercise program, or that the proposed duration of treatment has been defined. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.