

Case Number:	CM15-0105994		
Date Assigned:	06/10/2015	Date of Injury:	05/13/2014
Decision Date:	08/18/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	06/02/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 59 year old female, who sustained an industrial injury on 05/13/2014. The injured worker is currently off work. The injured worker is currently diagnosed as having rule out cervical disc protrusion; rule out cervical radiculitis versus radiculopathy, thoracic disc protrusion, rule out lumbar disc protrusion, rule out lumbar radiculitis versus radiculopathy, rule out right shoulder internal derangement, right forearm strain, left forearm strain, and depression. Treatment and diagnostics to date has included medications. In a progress note dated 03/17/2015, the injured worker presented with complaints of cervical spine, thoracic spine, lumbar spine, right shoulder, left shoulder, right forearm, and left forearm pain. Objective findings include decreased and painful range of motion of cervical spine, thoracic spine, lumbar spine, right shoulder, left shoulder, right forearm, and left forearm. The treating physician reported requesting authorization for functional capacity evaluation, acupuncture, Trans-cutaneous Electrical Nerve Stimulation Unit, and physiotherapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional capacity evaluation for the cervical, thoracic, lumbar spine, bilateral shoulder and forearm, quantity: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 12. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, Functional Capacity Evaluation.

Decision rationale: Regarding request for functional capacity evaluation, Occupational Medicine Practice Guidelines state that there is not good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. ODG states that functional capacity evaluations are recommended prior to admission to a work hardening program. The criteria for the use of a functional capacity evaluation includes case management being hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed explanation of a worker's abilities. Additionally, guidelines recommend that the patient be close to or at maximum medical improvement with all key medical reports secured and additional/secondary conditions clarified. Within the documentation available for review, there is no indication that the patient is close to or at MMI with case management being hampered by complex issues as outlined above. In the absence of clarity regarding those issues, the currently requested functional capacity evaluation is not medically necessary.

Acupuncture for the cervical, thoracic, lumbar spine, bilateral shoulder and forearm, once weekly for 6 weeks: Overturned

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Regarding the request for acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as "either a clinically significant improvement in activities of daily living or a reduction in work restrictions" and a reduction in the dependency on continued medical treatment". A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, the patient is noted to have chronic pain with no indication of a previous trial of acupuncture. As such, the currently requested acupuncture is medically necessary.

TENS (Transcutaneous Electrical Nerve Stimulation)/ EMS (Electric Muscle Stimulation) unit rental for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 114-117 of 127 Regarding the request for TENS/EMS, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is 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. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach, with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Within the documentation available for review, there is no indication of the type of stimulation that will be used in addition to TENS. Furthermore, the requested 6-week trial exceeds the recommendations of the CA MTUS and, unfortunately, there is no provision for modification of the current request. In the absence of clarity regarding those issues, the currently requested TENS/EMS is not medically necessary.

Physiotherapy for the cervical, thoracic, lumbar spine, bilateral shoulder and forearm once weekly for 6 weeks: Overtaken

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, Low Back, Shoulder, and Forearm/Wrist/Hand Chapters, Physical Medicine.

Decision rationale: Regarding the request for physiotherapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no indication of a prior trial of physiotherapy and the patient is noted to have range of motion deficits. In light of the above, the currently requested physiotherapy is medically necessary.