

<b>Case Number:</b>	CM15-0106000		
<b>Date Assigned:</b>	06/11/2015	<b>Date of Injury:</b>	05/29/2014
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	05/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 52 year old female injured worker suffered an industrial injury on 05/29/2014. The diagnoses included cervical radiculopathy, rule out cervical disc protrusion, lumbar disc protrusion with radiculopathy, right shoulder impingement syndrome and left shoulder internal derangement. The injured worker had been treated with physical therapy. On 4/8/2015 the treating provider reported the cervical spine had frequent moderate pain. The lumbar spine had moderate sharp low back pain. The shoulders had moderate sharp stabbing pain with numbness and tingling. On exam the cervical spine had reduced range of motion with tenderness and spasms. The lumbar spine had reduced range of motion with spasms and positive straight leg raise. The shoulders had reduced painful range of motion. The treatment plan included Acupuncture, Physiotherapy, Lumbar brace, TENS, Pain management consultation, Referral to orthopedic surgeon and Functional capacity evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture one times six (neck, low back, shoulders):** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** According to the MTUS guidelines, acupuncture can be considered when pain medications are not tolerated, or reduced. It may also be used as an adjunct to physical rehabilitation or surgical intervention to hasten functional recovery. Typical time frame needed to produce functional benefit is 3-6 sessions. There is mention of neck, back and shoulder pain and a trial of acupuncture would be appropriate as an adjunct to therapeutic exercise. This requested is supported.

**Physiotherapy one times six (neck, low back, shoulders):** Upheld

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

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

**Decision rationale:** The California MTUS recommends 8-10 sessions of physical therapy for various myalgias or neuralgias. The request falls within guideline parameters, and can be supported given neck, back, and shoulder complaints however, there is no mention of the total number of previous therapy sessions, and as a result, there is uncertainty if further sessions would exceed guidelines. Medical necessity has not yet been substantiated.

**Lumbar brace:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, LSO.

**Decision rationale:** ACOEM Guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states that lumbar supports are not recommended for prevention. They go on to state that lumbar supports are recommended as an option for compression fractures, spondylolisthesis, instability, and for treatment of nonspecific low back pain (weak evidence). There is no evidence of the above diagnoses within the submitted documentation and as such, this request cannot be supported.

**TENS/EMs unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 113-116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, TENS unit.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that TENS units can be utilized for the relief of musculoskeletal pain. It is recommended that there should be an initial 1 month trial of the use of a TENS unit. The modality of the utilization of the use of the TENS unit should be documented. The guidelines recommend that the TENS units can then be purchased or authorized for long-term use if there is documentation of pain relief, improved function with range of motion, and reduction in medication utilization. There is no mention of TENS unit being used as a rental, with short and long-term goals. Also, the body part that the TENS unit is intended to treat was not specified. Medical necessity has not yet been substantiated.

**Pain management consultation:** Overturned

**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 Consultation, Referrals Page(s): 87-89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Management Referral.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that patients can be referred to consultation with a pain specialist when the diagnosis is complex or when additional expertise will be beneficial to the medical management. In this case, Pain specialty input would be appropriate given the chronic widespread pain exhibited by the injured worker, failing conservative care. This request is certified.

**Referral to orthopedic surgeon:** Overturned

**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 2 General Approach to Initial Assessment and Documentation Page(s): 27.

**Decision rationale:** The CA MTUS Guidelines recommend a consultation to aid with diagnosis/prognosis and therapeutic management, recommend referrals to other specialists if a diagnosis is uncertain or exceedingly complex when there are psychosocial factors present, or when a plan or course of care may benefit from additional expertise. This injured worker has chronic pain, and expertise from an orthopedist would benefit the individual, and help guide future management. As such, this request is certified.

**Functional capacity evaluation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for duty chapter, FCE.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a number of functional assessment tools are available, including functional capacity evaluations (FCE) when re-assessing function and functional recovery. The ODG do not recommend proceeding with an FCE if the sole purpose is to determine a worker's effort or compliance and/or if the worker has returned to work without having an ergonomic assessment arranged. There should be mention of a previous failure to return to work, or documentation of conflicting medical reporting on precautions and/or fitness for modified duty work. There is no clear rationale as to why an FCE is needed or being requested by the treating provider. Without clarification, this request cannot be supported.