

Case Number:	CM15-0106244		
Date Assigned:	06/10/2015	Date of Injury:	06/01/2014
Decision Date:	08/18/2015	UR Denial Date:	05/27/2015
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:

This 33 year old female sustained an industrial injury to the back, neck and bilateral wrists on 6/1/14. Previous treatment included physical therapy, chiropractic therapy, acupuncture and medications. Magnetic resonance imaging bilateral wrists (4/21/15) showed small radiocarpal joint effusions. Magnetic resonance imaging left shoulder (4/26/15) showed tendinosis with minimal bursitis and minimal glenohumeral joint effusion. Documentation did not disclose the number of previous acupuncture sessions. Magnetic resonance imaging right shoulder (4/21/15) showed an interstitial tear, tendinosis, bursitis and osteoarthopathy. In a progress noted dated 4/22/15, the injured worker complained of pain to the upper back with radiation to bilateral shoulders and elbows, rated 6/10 on the visual analog scale, bilateral wrist pain rated 7-8/10 associated with numbness, ting, weakness and swelling, low back pain rated 4/10 with radiation to the right knee and frequent headaches. Physical exam was remarkable for tenderness to palpation to the cervical spine paraspinal musculature, upper trapezius, bilateral shoulders and bilateral wrist with normal reflexes and pulses. Current diagnoses included cervical spine sprain/strain, bilateral shoulder arthralgia and bilateral wrist sprain/strain. The treatment plan included continuing functional restoration and acupuncture twice a week for six weeks, requesting authorization for transcutaneous electrical nerve stimulator unit and hot and cold pack/wrap for home use and medications refills (Naproxen Sodium, Prilosec, Ultracet and topical compound creams).

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture 2 times a week for 6 weeks: Upheld

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, it appears the patient has undergone acupuncture previously. It is unclear how many sessions have previously been provided and there is no documentation of objective functional improvement from the therapy already provided. As such, the currently requested acupuncture is not medically necessary.

Functional restoration, range of motion (ROM), and muscle testing: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs, Criteria for the general use of multidisciplinary pain management programs, Work conditioning, Work hardening. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Flexibility.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 33, 89.

Decision rationale: Regarding the request for functional restoration, range of motion, and muscle testing, it is unclear what specific treatment is being done for "functional restoration." Occupational Medicine Practice Guidelines state that physical examination should be part of a normal follow-up visit including examination of the musculoskeletal system. A general physical examination for a musculoskeletal complaint typically includes range of motion and strength testing. Within the documentation available for review, it is unclear what specific treatment is being done for "functional restoration" and there is no indication of any functional improvement to support ongoing use of this treatment. Regarding ROM and muscle testing, the requesting physician has not identified why he is incapable of performing a standard musculoskeletal examination for this patient, or why additional testing above and beyond what is normally required for a physical examination would be beneficial in this case. In the absence of such documentation, the currently requested functional restoration, range of motion, and muscle testing is not medically necessary.

Purchase of heat/cold unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter, Heat/Cold Applications, Continuous-flow cryotherapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 174, 265, 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, Low Back, and Forearm/Wrist/Hand Chapter, Continuous-flow cryotherapy, cryotherapy, cold/heat packs, and heat therapy sections.

Decision rationale: Regarding the request for a heat/cold unit purchase, California MTUS supports the application of simple hot/cold packs. ODG also supports simple hot/cold packs, high-tech units such as cold therapy are supported only for some body parts after surgery, and then only for up to 7 days after surgery. Within the documentation available for review, there is no documentation of a rationale for the use of a formal heat/cold therapy unit rather than the application of simple heat/cold packs given the lack of evidence-based support for its use in the management of the patient's cited injuries. In the absence of such documentation, the currently requested heat/cold unit purchase is not medically necessary.

Purchase of wrap cold therapy multi use: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter, Heat/Cold Applications, Continuous-flow cryotherapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 174, 265, 300.

Decision rationale: Regarding the request for a cold therapy wrap purchase, California MTUS supports the application of simple cold packs. ODG also supports simple cold packs, high-tech devices such as cold therapy are supported only for some body parts after surgery, and then only for up to 7 days after surgery. Within the documentation available for review, there is no documentation of a rationale for the use of a cold therapy wrap rather than the application of simple cold packs given the lack of evidence-based support for its use in the management of the patient's cited injuries. In the absence of such documentation, the currently requested cold therapy wrap purchase is not medically necessary.