Case Number:	CM15-0016255		
Date Assigned:	03/18/2015	**Date of Injury:**	05/01/2013
Decision Date:	04/17/2015	**UR Denial Date:**	12/29/2014
Priority:	Standard	**Application Received:**	01/28/2015

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 Jersey, Michigan, California
Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 38-year-old male who sustained an industrial injury on 05/01/13. Initial complaints included pain in the neck and bilateral upper extremities. Initial diagnoses were not available in the submitted documentation. Prior treatments include physical therapy, acupuncture treatments, oral and transdermal medication, and a referral for psychological treatment, which the injured worker refused. Prior diagnostic testing includes MIR of the bilateral wrists/hands, x-rays, and EMG/NCV of the bilateral upper extremities. Current complaints include bilateral wrist and neck pain. In a progress note dated 12/08/14 the treating provider reports the plan of care as a trial course of occupational/physical therapy treatments, instruction in a home exercise program for his bilateral wrists and hands, as well as acupuncture treatment to his bilateral wrists ad hands. He was also to continue taking oral and transdermal medications, and undergo urine drug testing for compliance and a Functional Capacity Evaluation. The requested treatments include a Functional Improvement Measurement and a STP consult/acupuncture with acupuncture therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 STP consult/acupuncture with adjunct procedures/modalities 2 times a week for 4 weeks, STP consultation and initial 6 acupuncture therapy, plus 3 times per week for 2 months if functional improvement of produced, which will be documented via E/M visit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to MTUS 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 functional recovery. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Furthermore and according to MTUS guidelines, Acupuncture with electrical stimulation is the use of electrical current (microamperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites. The patient developed chronic neck pain and musculoskeletal disorders. He is a candidate for treatment with acupuncture. However, the frequency of the treatment should be reduced from 6 to 3 or less sessions. More sessions will be considered when functional and objective improvements are documented. In addition, the outcome of previous acupuncture sessions should be documented. Therefore, the request for 1 STP consult/acupuncture with adjunct procedures/modalities 2 times a week for 4 weeks, STP consultation and initial 6 acupuncture therapy, plus 3 times per week for 2 months if functional improvement of produced, which will be documented via E/M visit is not medically necessary.

1 functional improvement measurement with functional improvement measures using NIOSH testing for 30days, one baseline and one P&S complete functional improvement measurement: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Fitness of Duty.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 11. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Functional capacity evaluation (FCE), http://www.odg-twc.com/index.html; ERGONOMICS AND MUSCULOSKELETAL DISORDERS. http://www.cdc.gov/niosh/topics/ergonomics/.

Decision rationale: According to ODG guidelines, Functional capacity evaluation Recommended prior to admission to a Work Hardening (WH) Program, with preference for

assessments tailored to a specific task or job. Not recommend routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally. See entries for Work conditioning, work hardening in each body-part chapter, for example, the Low Back Chapter. Both job-specific and comprehensive FCEs can be valuable tools in clinical decision-making for the injured worker; however, FCE is an extremely complex and multifaceted process. Little is known about the reliability and validity of these tests and more research is needed. (Lechner, 2002) (Harten, 1998) (Malzahn, 1996) (Tramposh, 1992) (Isernhagen, 1999) (Wyman, 1999) Functional capacity evaluation (FCE), as an objective resource for disability managers, is an invaluable tool in the return to work process. (Lyth, 2001) There are controversial issues such as assessment of endurance and inconsistent or sub-maximum effort. (Schultz-Johnson, 2002) Little to moderate correlation was observed between the self-report and the Isernhagen Work Systems Functional Capacity Evaluation (FCE) measures. (Reneman, 2002) Inconsistencies in subjects' performance across sessions were the greatest source of FCE measurement variability. Overall, however, test-retest reliability was good and interrater reliability was excellent. (Gross, 2002) FCE subtests of lifting were related to RTW and RTW level for people with work-related chronic symptoms. Grip force was not related to RTW. (Matheson, 2002) Scientific evidence on validity and reliability is limited so far. An FCE is time-consuming and cannot be recommended as a routine evaluation. (Rivier, 2001) Isernhagen's Functional Capacity Evaluation (FCE) system has increasingly come into use over the last few years. (Kaiser, 2000) Ten well-known FCE systems are analyzed -- All FCE suppliers need to validate and refine their systems. (King, 1998) Compared with patients who gave maximal effort during the FCE, patients who did not exert maximal effort reported significantly more anxiety and self-reported disability, and reported lower expectations for both their FCE performance and for returning to work. There was also a trend for these patients to report more depressive symptomatology. (Kaplan, 1996) Safety reliability was high, indicating that therapists can accurately judge safe lifting methods during FCE. (Smith, 1994) FCE is a burdensome clinical tool in terms of time and cost, so this RCT evaluated the effectiveness of a short-form FCE protocol, and concluded that a short-form FCE appears to reduce time of assessment (43% reduction) while not affecting recovery outcomes when compared to standard FCE administration. Such a protocol may be an efficient option for therapists performing fitness-for-work assessments. (Gross, 2007) Credibility of both the FCE and FCE evaluator is critical. If the evaluee complains of evaluator bias, lack of expertise, or poor professional conduct, the FCE can be considered useless. (Genovese, 2009). Guidelines for performing an FCE: Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants. Consider an FCE if: 1) Case management is hampered by complex issues such as: Prior unsuccessful RTW attempts. Conflicting medical reporting on precautions and/or fitness for modified job. Injuries that require detailed exploration of a worker's abilities. 2) Timing is appropriate: Close or at MMI/all key medical reports secured. Additional/secondary conditions clarified. Do not proceed with an FCE if: The sole purpose is to determine a worker's effort or compliance. The worker has returned to work and an ergonomic assessment has not been arranged. (WSIB, 2003) There is no documentation that the patient fulfilled the above criteria for the evaluation of functional

improvement. Furthermore and according to ODG guidelines, MTUS guidelines and National Institute for Occupational Safety and Health (NIOSH) guidelines, there is no documentation and indication for the use of NIOSH equations for pain management. Therefore, the request for 1 functional improvement measurement with functional improvement measures using NIOSH testing for 30-days, one baseline and one P&S complete functional improvement measurement is not medically necessary.