

Case Number:	CM15-0169127		
Date Assigned:	09/09/2015	Date of Injury:	07/21/2009
Decision Date:	10/13/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	08/27/2015

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, Alabama, 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 56 year old male, who sustained an industrial injury on 7-21-091. Initial complaints were of continuous type trauma to multiple body areas of discomfort. The injured worker was diagnosed as having lumbar radiculopathy; anxiety; shoulder impingement brachial neuritis or radiculitis not otherwise specified; stomach functional disorders. Treatment to date has included physical therapy; chiropractic therapy; psychotherapy; acupuncture; cortisone injection to the right hip; trigger point injections lumbar spine (3-23-15); lumbar epidural steroid injection (3-23-15); medications. Diagnostics studies included abdominal sonogram (4-8-15); MRI left shoulder (7-29-15). Currently, the PR-2 notes dated 8-12-15 indicated the injured worker was in the office on this date as a follow-up. He reports he has a trigger point injection to the lumbar spine which helped minimally (3-23-15). He pays for acupuncture therapy out of his own pocket and medications to control his pain. He has a visit with another provider a colonoscopy. He complains of anxiety symptoms and posttraumatic stress disorder. He reports continued headaches. The office will request the injured worker to see an orthopedic spine surgeon and well as sport surgeon for his shoulder complaints. On physical examination, the provider notes cervical spine paravertebral muscles are tender with spasms present. Range of motion is restricted and sensations are reduced in the bilateral hands. His shoulder examination notes anterior shoulders are tender to palpation bilaterally with range of motion decreased in flexion and abduction plane. Impingement sign is positive bilaterally. The lumbar spine paravertebral muscles are tender with spasm and range of motion is restricted. His straight leg raise test is positive bilaterally with sensation and motor grossly intact. He has ongoing active peptic ulcer disease diagnosed with an upper gastrointestinal endoscopy 2-7-08 per the AME report dated 4-8-15. He had a MRI of his left shoulder on 7-29-15 revealing mild supraspinatus

tendinosis with no rotator cuff tear. A possible tear of the left posterior labrum superiorly is noted and recommended a MR Arthrogram for better evaluation. There are mild acromioclavicular joint degenerative changes. The provider's treatment plan recommended continued medications as before, but wants the MR Arthrogram of the left shoulder to rule out a labral tear. He is requesting a Functional Capacity Exam (FCE) for appropriate restrictions for work. A Request for Authorization is dated 8-27-15. A Utilization Review letter is dated 8-21-15 and non-certification was for a Functional Capacity Exam and Bilateral Carpal Tunnel Syndrome braces. Authorized services were for a left shoulder MR Arthrogram and an Orthopedic consult for cervical and lumbar spine and bilateral shoulders. The provider is requesting authorization of Functional Capacity Exam and Bilateral Carpal Tunnel Syndrome braces.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Capacity Exam QTY 1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Chronic pain programs, early intervention, Chronic pain programs (functional restoration programs).

Decision rationale: According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for a pain management evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. In the chronic pain programs, early intervention section of MTUS guidelines stated: "Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach: (a) the patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity. (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis. (c) There is a previous medical history of delayed recovery. (d) The patient is not a candidate where surgery or other treatments would clearly be warranted. (e) Inadequate employer support. (f) Loss of employment for greater than 4 weeks. The most discernable indication of at risk status is lost time from work of 4 to 6 weeks. (Mayer 2003)". There is no documentation that the patient condition require functional capacity evaluation. There is no strong scientific evidence that functional capacity evaluation predicts the patient ability to perform his work. In addition, the provider should document that the patient reached his MMI. The requesting physician should provide a documentation supporting the medical necessity for this evaluation. The documentation should include the reasons, the specific goals and end point for Functional Capacity Evaluation. Therefore, the request for Initial Functional Capacity Evaluation is not medically necessary.

Bilateral Carpal Tunnel Syndrome braces QTY 1: 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)

Treatment, Integrated Treatment/Disability Duration Guidelines, Forearm, Wrist & Hand (Acute & Chronic) (Not including "Carpal Tunnel Syndrome") (updated 5/8/2013).

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Physical Methods.

Decision rationale: According to MTUS guidelines, splinting is "Recommend splinting of wrist in neutral position at night & day prn, as an option in conservative treatment. Use of daytime wrist splints has positive, but limited evidence. Splinting after surgery has negative evidence. When treating with a splint, there is scientific evidence to support the efficacy of neutral wrist splints in CTS, and it may include full-time splint wear instructions as needed, versus night-only. Carpal tunnel syndrome may be treated initially with a splint and medications before injection is considered, except in the case of severe CTS (thenar muscle atrophy and constant paresthesias in the median innervated digits). Outcomes from carpal tunnel surgery justify prompt referral for surgery in moderate to severe cases. Nevertheless, surgery should not be performed until the diagnosis of CTS is made by history, physical examination and possible electrodiagnostic studies. Symptomatic relief from a cortisone/anesthetic injection will facilitate the diagnosis, however the benefit from these injections although good is short-lived. Two prospective randomized studies show that there is no beneficial effect from postoperative splinting after carpal tunnel release when compared to a bulky dressing alone. In fact, splinting the wrist beyond 48 hours following CTS release may be largely detrimental, especially compared to a home physical therapy program. (Banta, 1994) (Bury, 1995) (Courts, 1995) (Finsen, 1999) (Walker, 2000) (Gerritsen-JAMA, 2002) (Goodyear-Smith, 2004) (Muller, 2004) (Sevim, 2004) (Werner, 2005) (Premoselli, 2006) (Ucan, 2006) A hand brace significantly improves symptoms after four weeks. There is limited evidence that a nocturnal hand brace improves symptoms, hand function and overall patient-reported change in the short-term (up to four weeks of use). There is limited evidence that night-only wrist splint use is equally effective as full-time wrist splint use in improving short-term symptoms and hand function. There is limited evidence that neutral wrist splinting results in superior short-term overall and nocturnal symptom relief (at two weeks) when compared with wrist splinting in extension. Furthermore, limited evidence suggests that short-term daytime symptom relief is similar for both splint groups. (O'Conner-Cochrane, 2003) It is concluded that steroid injections and wrist splinting may be effective for relief of CTS symptoms but have a long-term effect in only 10 percent of patients. Symptom duration of less than 3 months and absence of sensory impairment at presentation are predictive of a lasting response to conservative treatment. Selected patients (i.e., with no thenar wasting or obvious underlying cause) presenting with mild to moderate carpal tunnel syndrome may receive either a single steroid injection or wear a wrist splint for 3 weeks. This will allow identification of the 10 percent of patients who respond well to conservative therapy and do not need surgery. (Graham, 2004) Statistical evaluation identified five factors which were important in predicting lack of response to wrist splints: (1) age over 50 years, (2) duration over ten months, (3) constant paraesthesiae, (4) stenosing flexor tenosynovitis, and (5) a Phalen's test positive in less than 30 seconds. When none of these factors was present, 66% of patients were cured by medical therapy, 40% of patients with one factor, 17% with two factors, and 7% with three factors, and no patient with four or five factors present was cured by medical management. (Kaplan, 1990) Data suggest that splinting is most effective if applied within three months of symptom onset. (Kruger, 1991) This systematic review found that the usefulness of splinting as initial treatment for improving CTS symptoms is still supported by recent literature, but these effects are temporary. (Bernardino, 2011)". There is no documentation that the patient's wrist condition requires keeping the wrist in a neutral position. There is no documented findings consistent with carpal tunnel syndrome. Therefore, the request for Bilateral Carpal Tunnel Syndrome braces is not medically necessary.