MAXIMUS Federal Services

Case Number:	CM15-0194681		
Date Assigned:	10/08/2015	Date of Injury:	07/05/2013
Decision Date:	11/18/2015	UR Denial Date:	09/11/2015
Priority:	Standard	Application Received:	10/05/2015

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, Indiana, New York
Certification(s)/Specialty: Internal 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 was a 51 year old male, who sustained an industrial injury, July 15, 2013. The injured worker was undergoing treatment for status post resecting left forearm hematoma, left upper extremity crush injury, left wrist, left forearm and left elbow and contusion of the left arm. According to progress note of August 31, 2015, the injured worker's chief complaint was persistent moderate to severe pain in the left forearm left wrist and left hand was rated at 9 out of 10. The low back pain and bilateral knee pain was rated at 9 out of 10. The injured worker was experiencing numbness, stiffness, and tingling of the left forearm, left wrist and all the fingers of the left hand with locking in the fingers. The injured worker was reporting decreased grip strength of the left hand. The physical exam noted a well-healed surgical incision scar. Upon palpation of the aforementioned incision scar there was tenderness was elicited. Palpation of the left wrist and hand elicits tenderness. There was limited range of motion of the left hand, which showed the inability to make a fist. The injured worker previously received the following treatments status post resecting left forearm hematoma, Cyclobenzaprine, Nabumetone and Omeprazole. The RFA (request for authorization) dated August 31, 2015; the following treatments were requested acupuncture 2 times a week for 4 weeks for the left forearm, wrist and hand and functional capacity evaluation. The UR (utilization review board) modified certification on September 11, 2015; for acupuncture 2 times a week for 4 weeks for the left forearm, wrist and hand and denied a functional capacity evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture 2x4, unspecified body part(s): Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Acupuncture treatment.

Decision rationale: Pursuant to the Acupuncture Medical Treatment Guidelines and the Official Disability Guidelines, acupuncture two times per week times four weeks unspecified body part is not medically necessary. Acupuncture is not recommended for acute low back pain. Acupuncture is recommended as an option for chronic low back pain using a short course of treatment in conjunction with other interventions. The Official Disability Guidelines provide for an initial trial of three - four visits over two weeks. With evidence of objective functional improvement, a total of up to 8 to 12 visits over 4 to 6 weeks may be indicated. The evidence is inconclusive for repeating this procedure beyond an initial short period. In this case, the injured worker's working diagnoses are status post resection left forearm hematoma; left upper extremity crush injury left wrist, left forearm and left elbow; and contusion of left arm. Date of injury is July 15, 2013. Request for authorization is September 1, 2015. According to August 31, 2015 progress note, the injured worker has ongoing severe pain in the left forearm, wrist and hand. There are also complaints of low back pain and bilateral knee pain. Objectively, there is tenderness over the left forearm wrist and hand with decreased range of motion of the left hand. This is an initial acupuncture request. The guidelines recommend an initial trial of 3-4 visits. The treating provider requested eight sessions, in excess of the recommended guidelines. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, and a request for eight sessions in excess of the recommended 3-4 clinical trial, acupuncture two times per week times four weeks unspecified body part is not medically necessary.

Functional Capacity Evaluation, unspecified body part(s): 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 for Duty, Functional capacity evaluation (FCE).

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Job Analysis, Work Activities, Work-Relatedness.

Decision rationale: Pursuant to the ACOEM, functional capacity evaluation unspecified body part(s) is not medically necessary. The guidelines state the examiner is responsible for determining whether the impairment results from functional limitations and to inform the examinee and the employer about the examinee's abilities and limitations. The physician should state whether work restrictions are based on limited capacity, risk of harm or subjective examinees tolerance for the activity in question. There is little scientific evidence confirming functional capacity evaluations to predict an individual's actual capacity to perform in the

workplace. For these reasons it is problematic to rely solely upon functional capacity evaluation results for determination of current work capabilities and restrictions. The guidelines indicate functional capacity evaluations are recommended to translate medical impairment into functional limitations and determine work capability. Guideline criteria functional capacity evaluations include prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modify job, the patient is close to maximum medical improvement, and clarification any additional secondary conditions. FCEs are not indicated when the sole purpose is to determine the worker's effort for compliance with the worker has returned to work and an ergonomic assessment has not been arranged. In this case, the injured worker's working diagnoses are status post resection left forearm hematoma; left upper extremity crush injury left wrist, left forearm and left elbow; and contusion of left arm. Date of injury is July 15, 2013. Request for authorization is September 1, 2015. According to August 31, 2015 progress note, the injured worker has ongoing severe pain in the left forearm, wrist and hand. There are also complaints of low back pain and bilateral knee pain. Objectively, there is tenderness over the left forearm wrist and hand with decreased range of motion of the left hand. The guidelines indicate functional capacity evaluations are recommended to translate medical impairment into functional limitations and determine work capability. FCEs are not indicated when the sole purpose is to determine the worker's effort for compliance with the worker has returned to work and an ergonomic assessment has not been arranged. There is no documentation of prior unsuccessful return to work attempts. Documentation states the functional capacity evaluation is indicated to determine the current and future appropriateness of required job duties for the employee. This is an inadequate clinical rationale. Additionally, there is little scientific evidence confirming functional capacity evaluations to predict an individual's actual capacity to perform in the workplace. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation of prior unsuccessful return to work attempts and little scientific evidence confirming functional capacity evaluations predict an individual's actual capacity to perform the workplace, functional capacity evaluation unspecified body part(s) is not medically necessary.