

Case Number:	CM15-0207928		
Date Assigned:	10/26/2015	Date of Injury:	09/17/2013
Decision Date:	12/30/2015	UR Denial Date:	10/12/2015
Priority:	Standard	Application Received:	10/22/2015

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 York
 Certification(s)/Specialty: Anesthesiology

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 52 year old male, who sustained an industrial injury, September 17, 2013. The injured worker was undergoing treatment for bilateral shoulder AC arthrosis, bilateral shoulder tendonitis, bilateral shoulder bursitis, right shoulder labral tear, lumbar spine sprain and or strain, lumbar spine canal stenosis, lumbar DDD (degenerative disc disease), lumbar HNP (herniated nucleus pulposus), lumbar radiculopathy and lumbar spine facet arthropathy. According to progress note of September 17, 2015, the injured worker's chief complaint was the neck, both shoulders, lower back, both knees and both feet. The injured worker rated the neck pain 4-5 out of 10. The bilateral shoulder pain was radiating down the arms to the fingers with associated spasms. The pain was rated at 5 out of 10. The pain was described as constant moderate to severe. The pain was aggravated by gripping, grasping, reaching, lifting and doing work above the shoulder level. The lower back pain was rated at 4-5 out of 10. The pain was described as constant, moderate to severe. The pain was associated with numbness and tingling of the bilateral lower extremities. The pain was aggravated by sitting, standing, walking, bending, raising from a seated position, ascending or descending stairs and stooping. The pain was aggravated by activities of daily living such as getting dressed and performing personal hygiene. The physical examination of the shoulders noted tenderness of the delto-pectoral groove and at the insertion of the supraspinatus muscle bilaterally. There was decreased range of motion of the bilateral shoulders in all planes. The sensory response testing to pinprick and light touch were diminishes over the C5, C6, C7, C8 and T1 dermatomes in the bilateral upper extremities. The motor strength was decreased bilaterally secondary to pain. The examination of the lumbar

spine noted decreased range of motion in all planes. There was tenderness with palpation at the lumbar paraspinal muscles. The sensory exam noted decreased sensation to pinprick and light touch at the L4, L5 and S1 dermatomes bilaterally. The motor strength was decreased bilaterally due to pain. The injured worker previously received the following treatments occupational therapy and Ketoprofen cream. The UR (utilization review board) denied certification on October 12, 2015; for a functional capacity evaluation for the back, trigger point injection of the lumbar spine and left shoulder trapezius, aquatic therapy one time a week for six weeks for the lumbar spine and Tizanidine HCL 2mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

FCE (Functional Capacity Evaluation): 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): Functional improvement measures, Return to work, Work conditioning, work hardening. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) FCE.

Decision rationale: The CA MTUS states that a functional capacity evaluation (FCE) is recommended under certain specific circumstances. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. It should include work functions and or activities of daily living, self-report of disability, objective measures of the patient's functional performance and physical impairments. It is not recommended routinely as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally. According to the ODG, 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. An 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. FCE's should not be conducted unless maximum medical improvement (MMI) has been achieved or is anticipated to occur shortly. In this case, there is no documentation of the patient's physical impairments and it is unclear if he has failed return-to-work attempts. There are no specific indications for an FCE. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Trigger point injections to the lumbar spine and left shoulder/trapezius: 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): Trigger point injections.

Decision rationale: According to California MTUS Guidelines, trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: 1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; 2) Symptoms have persisted for more than three months; 3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; 4) Radiculopathy is not present on exam; 5) Not more than 3-4 injections per session; 6) No repeat injections unless greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; 7) Frequency should be at an interval less than 2 months; 8) Trigger point injections with any substance other than local anesthetic with or without steroid are not recommended. There is no documentation provided indicating circumscribed trigger points with palpable twitch response and referred pain. Medical necessity for the requested injections has not been established. The requested trigger point injections are not medically necessary.

Aquatic therapy 1 times per week for 6 weeks for the lumbar spine: 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): Aquatic therapy.

Decision rationale: According to CA MTUS Guidelines (2009), aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight-bearing is desirable (for example, extreme obesity). Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities may be required to preserve most of these gains. In this case, there is no documentation of significant objective and functional deficits in the physical exam to support the need for reduced weight-bearing in order to progress with therapy. In addition, the documentation did not indicate that the patient was severely obese or indicate that he had difficulty ambulating without assistance. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Sacroiliac joint injection: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Sacroiliac joint injections.

Decision rationale: Sacroiliac joint injections (SIJ) are recommended as an option if the patient has failed at least 4-6 weeks of aggressive conservative therapy. Sacroiliac dysfunction is poorly defined and the diagnosis is often difficult to make due to the presence of other low back pathology (including spinal stenosis and facet arthropathy). The diagnosis is also difficult to make as pain symptoms may depend on the region of the SI joint that is involved (anterior, posterior, and/or extra-articular ligaments). Pain may radiate into the buttock, groin and entire ipsilateral lower limb, although if pain is present above L5, it is not thought to be from the SI joint. Criteria for the use of SIJ blocks include that the patient has had and failed at least 4-6 weeks of aggressive conservative therapy including, physical therapy (PT), home exercise and medication management. In this case, it is unclear if the patient's pain pattern is due to SI joint dysfunction. There was no documentation of positive exams with regard to the SIJ. Medical necessity for the SIJ injections is not established. The requested procedure is not medically necessary.

Bilateral S1 joint injection under Fluoroscopic guidance: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Sacroiliac joint injections.

Decision rationale: Sacroiliac joint injections (SIJ) are recommended as an option if the patient has failed at least 4-6 weeks of aggressive conservative therapy. Sacroiliac dysfunction is poorly defined and the diagnosis is often difficult to make due to the presence of other low back pathology (including spinal stenosis and facet arthropathy). The diagnosis is also difficult to make as pain symptoms may depend on the region of the SI joint that is involved (anterior, posterior, and/or extra-articular ligaments). Pain may radiate into the buttock, groin and entire ipsilateral lower limb, although if pain is present above L5, it is not thought to be from the SI joint. Criteria for the use of SIJ blocks include that the patient has had and failed at least 4-6 weeks of aggressive conservative therapy including, physical therapy (PT), home exercise and medication management. In this case, it is unclear if the patient's pain pattern is due to SI joint dysfunction. There is no documentation of positive exams with regard to the SIJ. Medical necessity for the bilateral SIJ injections under fluoroscopic guidance has not been established. The requested injections are not medically necessary.

Tizanidine HEL 2mg #60: 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): Muscle relaxants (for pain).

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha₂-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and considered an adjunct treatment for fibromyalgia. According to CA MTUS Guidelines, muscle relaxants have not been considered any more effective than non-steroidal anti-inflammatory drugs (NSAIDs) for pain or overall improvement. There is no additional benefit shown in combination with NSAIDs. In addition, sedation is the most commonly reported adverse effect of muscle relaxant medications. In this case, there was documentation that this patient had muscle spasms. Medical necessity for the requested muscle relaxant has not been established. The requested medication is not medically necessary.