

Case Number:	CM15-0025793		
Date Assigned:	02/18/2015	Date of Injury:	07/28/2013
Decision Date:	03/31/2015	UR Denial Date:	01/13/2015
Priority:	Standard	Application Received:	02/11/2015

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: Florida

Certification(s)/Specialty: Family Practice

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 55 year old female sustained an industrial injury on 7/28/13, with subsequent ongoing neck, back and bilateral upper extremity pain. Magnetic resonance imaging left elbow, bilateral wrists and thoracic spine (2/27/14) were normal. Magnetic resonance imaging cervical spine (2/27/14) showed disc dessication and protrusion. Magnetic resonance imaging lumbar spine (2/27/14) showed multilevel degenerative disc disease with an annular tear at L4-5 and disc protrusion. In a PR-2 dated 12/17/14, the injured worker complained of neck, back, bilateral shoulder, arms, elbow and forearm pain with pain and numbness to bilateral wrists and hands, rated 6-8/10 on the visual analog scale. Electromography/nerve conduction velocity test bilateral upper extremity (6/30/14) showed right carpal tunnel syndrome. Physical exam was remarkable for tenderness to palpation to the cervical spine, thoracic spine, lumbar spine, bilateral shoulders, bilateral arms, bilateral elbows, bilateral forearms, bilateral wrists and bilateral hands with restricted range of motion, positive straight leg raise, positive cervical compression test and positive impingement and supraspinatus tests. Current diagnoses included cervical spine sprain/strain with radiculitis and disc protrusions, thoracic spine sprain/strain, lumbar spine sprain/strain, left shoulder labral tear and impingement, lateral epicondylitis, bilateral elbow strain/sprain, bilateral wrist strain/sprain with chronic overuse syndrome, right carpal tunnel syndrome, depression, anxiety and sleep disturbance. The treatment plan included acupuncture to bilateral shoulders twice a week for six weeks, magnetic resonance imaging right shoulder and a physical performance functional capacity evaluation to ensure that the injured worker can safely meet the physical demands of her job. On 1/13/15, Utilization Review non-certified a

request for magnetic resonance imaging of the right shoulder and Physical performance functional capacity evaluation. Utilization Review modified a request for acupuncture therapy 2 times a week for 6 weeks for bilateral shoulders to four sessions of acupuncture therapy for bilateral shoulders. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture therapy 2 times a week for 6 weeks for bilateral shoulders: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acupuncture, pages 8-11 Page(s): Acupuncture, pages 8-11.

Decision rationale: In accordance with California MTUS Acupuncture guidelines (c) Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20 (ef). Section 9792.20 e and f are defined as follows, (e) Evidence-based means based, at a minimum, on a systematic review of literature published in medical journals included in MEDLINE. (f) Functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment. This patient's physician requested two treatments a week for 6 weeks. A total of 12 treatments. This request exceeds MTUS guideline recommendations. Therefore, this request is considered not medically necessary and appropriate.

MRI of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Shoulder Complaints Page(s): 207-212.

Decision rationale: MTUS guidelines state regarding shoulder imaging criteria: Primary criteria for ordering imaging studies are: -Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems) -Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon) -Failure to progress in a strengthening program intended to avoid surgery. -Clarification of the

anatomy prior to an invasive procedure (e.g., a full- thickness rotator cuff tear not responding to conservative treatment). This patient had an MRI performed of her right shoulder in 3/2014. A repeat MRI is not routinely recommended unless there has been a significant change in symptoms. This patient's medical records do not document any significant change in her symptoms nor any red flag conditions that would necessitate a repeat MRI. There is no documentaiton of failure to progress in a strengthening program intended to avoid surgery. There is also not any documentation of planned invasive procedures planned for which this MRI would be necessary to clarify anatomy. Likewise, this request is not considered medically necessary.

Physical performance functional capacity evaluation: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
FUNCTIONAL CAPACITY EVALUATIONPreplacement and periodic examinations, page 11-12 Page(s): page.

Decision rationale: California MTUS guidelines state, The clinician must be aware of the sensitivity and specificity of any tests used and their applicability to real job situations. Tests should have been evaluated in working populations and determined to reflect true job demands. At present, there is not good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. The preplacement examination process will determine whether the employee is capable of performing in a safe manner the tasks identified in the job-task analysis." As the prior quotation makes clear, MTUS guidelines do not fully support Functional capacity evaluations. Also, in this patient's case, records state that this patient has previously undergone a Functional Capacity Evaluation, and these records do not make it clear why a repeat evaluation is now necessary. Likewise, this request is not considered medically necessary.