

Case Number:	CM15-0040514		
Date Assigned:	03/10/2015	Date of Injury:	03/11/2007
Decision Date:	05/08/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	03/03/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 61 year old female sustained an industrial injury to the neck, bilateral shoulders, bilateral elbows and back via cumulative trauma from 2/13/07 to 3/15/07. In a PR-2 dated 1/23/15, the injured worker complained of ongoing cervical spine, thoracic spine, lumbar spine, bilateral shoulders, bilateral elbows and bilateral index finger pain rated 7-9/10 on the visual analog scale. The injured worker also complained of sleep loss due to pain. physical exam was remarkable for tenderness to palpation to the cervical spine, thoracic spine, lumbar spine with spasms and decreased range of motion and tenderness to palpation to bilateral shoulders and elbows with limited range of motion. Current diagnoses included cervical radiculopathy, cervical spine sprain/strain, thoracic sprain/strain, lumbar spine radiculopathy, lumbar sprain/strain, bilateral shoulder and elbow sprain/strain and other insomnia. The injured worker was currently receiving chiropractic therapy and physical therapy. The treatment plan included continuing medications (Anaprox, Prilosec, Tramadol and Cyclobenzaprine), ongoing physical therapy and chiropractic therapy and a request for Functional Capacity Evaluation with Functional Improvement Measure, using NIOSH testing.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Capacity Evaluation with Functional Improvement Measure, using NIOSH testing: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for duty, functional capacity evaluation.

Decision rationale: The official disability guidelines recommends a functional capacity evaluation for individuals who have had unsuccessful return to work attempts or are stated to be close to or at maximum medical improvement. The UR physician acknowledges that "there is documentation indicating case management is hampered by complex issues" and also cites that this is the most important indication for FCEs. It is unclear why he concluded that the request is not medically necessary. Also, p48 of the MTUS notes that FCEs are recommended. The request is medically necessary.

Extracorporeal shockwave therapy (ESWT): Overturned

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) Shoulder, extracorporeal shockwave therapy.

Decision rationale: I respectfully disagree with the UR physician's assertion that ESWT is not covered by the ODG. The official disability guidelines recommends extracorporeal shock wave therapy for certain conditions to include adhesive capsulitis of the shoulder potentially lateral epicondylitis of elbow as well as plantar fasciitis. The request is medically necessary.

LINT: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (NMES) Page(s): 121.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Gorenberg M, Schwartz K. Imaging-guided hyperstimulation analgesia in low back pain. Journal of Pain Research. 2013;6:487-491. doi:10.2147/JPR.S47540.

Decision rationale: I respectfully disagree with the UR physician's use of the NMES guidelines in the MTUS for the assessment of medical necessity for this device, as it is a different modality. "Hyper-stimulation analgesia" with localized, intense, low-rate electrical pulses applied to painful

AATPs was found to be effective in 95% patients with chronic nonspecific low back pain, in a clinical validation study noted above. The request is medically necessary.

Trigger Point Impedance Imaging (TPII) followed by LINT: 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 Gorenberg M, Schwartz K. Imaging-guided hyperstimulation analgesia in low back pain. *Journal of Pain Research*. 2013;6:487-491. doi:10.2147/JPR.S47540.

Decision rationale: The appropriateness of the second part of this request (LINT) has been addressed in the prior assessment for medical necessity. Since the indication for LINT therapy has already been established, there is no need for Trigger Point Impedance Imaging to assess for the appropriateness of LINT therapy. Thus, the request is not medically necessary.