

Case Number:	CM15-0062587		
Date Assigned:	04/08/2015	Date of Injury:	05/01/1998
Decision Date:	05/12/2015	UR Denial Date:	03/04/2015
Priority:	Standard	Application Received:	04/02/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 53-year-old female sustained an industrial injury to the neck and back on 5/1/98. Previous treatment included magnetic resonance imaging, physical therapy, transcutaneous electrical nerve stimulator unit, cognitive behavioral therapy, acupuncture and medications. In a PR-2 dated 2/11/15, the injured worker complained of pain to the back, bilateral wrists, bilateral shoulder and cervical spine. Physical exam was remarkable for cervical spine with active range of motion in all six planes, cervical spine and thoracic spine with paraspinal musculature tenderness to palpation and left wrist with erythema, swelling and increased paresthesia. Current diagnoses included shoulder joint pain, vertiginous syndromes other disorders vestibular system, thoracic spine pain, chronic pain syndrome, chronic fatigue syndrome, carpal tunnel syndrome and disturbance of skin sensation. The treatment plan included refilling current diagnoses included medications (Norco, Opana, Relafen, Venlafaxine and Voltaren Gel), electro-myography/nerve conduction velocity test upper extremity and cervical spine and thoracic spine magnetic resonance imaging. The physician noted that he believed it was medically necessary to monitor the structural pathology of the cervical spine and thoracic spine on a regular basis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient MRI of the cervical and thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176-177. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck Chapter, and MRI Topic.

Decision rationale: Regarding the request for cervical MRI, guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Guidelines also recommend MRI after 3 months of conservative treatment. Within the documentation available for review, there is no indication of any red flag diagnoses. Additionally there is clear discussion of what prior imaging and work up to date has revealed. This is a remote injury, and therefore a prior discussion of diagnostic studies to date should be included in any rationale for a Cervical MRI. In the absence of such documentation, the requested cervical MRI is not medically necessary.

Electromyograph (EMG)/Nerve conduction velocity (NCV) of bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 177-179.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-182. Decision based on Non-MTUS Citation ODG Neck Chapter, Electrodiagnostic Studies, Electromyography, Nerve Conduction Studies.

Decision rationale: Regarding the request for EMG of bilateral upper extremities, ACOEM Practice Guidelines state that the electromyography and nerve conduction velocities including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Within the documentation available for review, there are no recent physical examination that includes comprehensive neurologic testing of sensory, deep tendon reflexes, and gait assessment. Motor testing was documented to be normal in a progress note on 4/8/15 that was associated with this request. At minimum, there should be documentation of abnormality on exam to warrant further investigation with electrodiagnostic testing. In the absence of such documentation, the currently requested EMG of bilateral upper extremities is not medically necessary.

Functional capacity evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional improvement measures.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 12. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty

Chapter, Functional Capacity Evaluation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 1 Pages 12 & Chapter 7, Pages 137-138.

Decision rationale: The CA MTUS does not specifically address functional capacity evaluations. Other well-established guidelines include ACOEM and ODG. ACOEM Chapter 7 Functional Capacity Evaluation states on pages 137-138: "The employer or claim administrator may request functional ability evaluations, also known as Functional Capacity Evaluations, to further assess current work capability. These assessments also may be ordered by the treating or evaluating physician, if the physician feels the information from such testing is crucial." The Official Disability Guidelines (ODG), Fitness for Duty Chapter, Functional Capacity Evaluation state that FCE's are: "Recommended prior to admission to a Work Hardening (WH) Program. See entries for Work conditioning, work hardening in each body-part chapter, for example, the Low Back Chapter. Both job-specific and comprehensive FCEs can be valuable tools in clinical decision-making for the injured worker; however, FCE is an extremely complex and multifaceted process. Little is known about the reliability and validity of these tests and more research is needed. (Lechner, 2002) (Harten, 1998) (Malzahn, 1996) (Tramposh, 1992) (Isernhagen, 1999) (Wyman, 1999) Functional capacity evaluation (FCE), as an objective resource for disability managers, is an invaluable tool in the return to work process. (Lyth, 2001) There are controversial issues such as assessment of endurance and inconsistent or sub-maximum effort. (Schultz-Johnson, 2002) Little to moderate correlation was observed between the self-report and the Isernhagen Work Systems Functional Capacity Evaluation (FCE) measures. (Reneman, 2002) Inconsistencies in subjects' performance across sessions were the greatest source of FCE measurement variability. Overall, however, test-retest reliability was good and interrater reliability was excellent. (Gross, 2002) FCE subtests of lifting were related to RTW and RTW level for people with work-related chronic symptoms. Grip force was not related to RTW. (Matheson, 2002) Scientific evidence on validity and reliability is limited so far. An FCE is time-consuming and cannot be recommended as a routine evaluation. (Rivier, 2001) Isernhagen's Functional Capacity Evaluation (FCE) system has increasingly come into use over the last few years. (Kaiser, 2000) Ten well-known FCE systems are analyzed. All FCE suppliers need to validate and refine their systems. (King, 1998) Compared with patients who gave maximal effort during the FCE, patients who did not exert maximal effort reported significantly more anxiety and self-reported disability, and reported lower expectations for both their FCE performance and for returning to work. There was also a trend for these patients to report more depressive symptomatology. (Kaplan, 1996) Safety reliability was high, indicating that therapists can accurately judge safe lifting methods during FCE. (Smith, 1994) FCE is a burdensome clinical tool in terms of time and cost, so this RCT evaluated the effectiveness of a short-form FCE protocol, and concluded that a short-form FCE appears to reduce time of assessment (43% reduction) while not affecting recovery outcomes when compared to standard FCE administration. Such a protocol may be an efficient option for therapists performing fitness-for-work assessments. (Gross, 2007) Credibility of both the FCE and FCE evaluator is critical. If the evaluate complains of evaluator bias, lack of expertise, or poor professional conduct, the FCE can be considered useless. (Genovese, 2009) Guidelines for performing an FCE: If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A 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. The report should be

accessible to all the return to work participants. Consider an FCE if 1. Case management is hampered by complex issues such as: Prior unsuccessful RTW attempts. Conflicting medical reporting on precautions and/or fitness for modified job. Injuries that require detailed exploration of a worker's abilities. 2. Timing is appropriate: Close or at MMI/all key medical reports secured. Additional/secondary conditions clarified. Do not proceed with an FCE if the sole purpose is to determine a worker's effort or compliance. The worker has returned to work and an ergonomic assessment has not been arranged. (WSIB, 2003)" Within the documentation available for review, there is no indication that there has been prior unsuccessful return to work attempts, conflicting medical reporting, or injuries that would require detailed exploration. This is a remote injury and the progress note on 4/8/15 associated with this request does not contain sufficient rationale as to why this testing is crucial at this time. In the absence of clarity regarding those issues, the currently requested functional capacity evaluation is not medically necessary.