MAXIMUS Federal Services

Case Number:	CM15-0083206		
Date Assigned:	05/05/2015	Date of Injury:	12/05/2014
Decision Date:	06/29/2015	UR Denial Date:	04/22/2015
Priority:	Standard	Application Received:	04/30/2015

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: Texas, Florida, California
Certification(s)/Specialty: Preventive Medicine, Occupational 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 is a 44-year-old female who sustained an industrial injury on 12/05/2014. Diagnoses include brachial neuritis/radiculitis, neuralgia, neuritis and radiculitis, sprain and strains of the neck and sprains and strain of the lumbar and thoracic strain. Treatment to date has included diagnostic studies, medications, and physical therapy. A physician progress note dated 04/08/2015 documents the injured worker has sharp neck pain that radiates into both shoulders and arms with numbness 7 out of 10, mid back pain/stiffness 6 out of 10, sharp low back pain radiating into the left leg with numbness 8 out of 10. Her cervical range of motion decreased by 20% in all planes of motion, pain end range forward flexion, and decrease lumbar range of motion 25% with pain. Straight Leg Raise and bilateral Kemps are positive. Shoulder depression is positive bilaterally. There is tenderness at C1-C6, T5-L4 spinous processes and paraspinal muscles. The treatment plan is for physical therapy, medication consultation, and x rays of the cervical, thoracic and lumbar spine. Treatment requested is for Cardio respiratory diagnostic testing, Initial functional captivity evaluation, ROM test 1x a month, and acupuncture treatment trial 1xwk x 6wks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Rom test 1x a month: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low back, under Range of Motion.

Decision rationale: This claimant was injured 6 months ago. There is pain in the neck, shoulder and arms, and subjective numbness. Cervical ROM is decreased by 20%. The acupuncture is proposed 6 sessions over 6 weeks. Regarding range of motion measurement, the current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. The ODG notes: Not recommended as primary criteria, but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent. This has implications for clinical practice as it relates to disability determination for patients with chronic low back pain, and perhaps for the current impairment guidelines of the American Medical Association. (Parks, 2003) (Airaksinen, 2006) They do not recommend computerized measures of lumbar spine range of motion, which can be done with inclinometers, and where the result (range of motion) is of unclear therapeutic value. In this case, ROM is done simply as part of a physical examination, and need not be especially done with special equipment, or by any other means. The request is appropriately not medically necessary.

acupuncture treatment trial 1xwk x 6wks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The MTUS notes frequency and duration of acupuncture or acupuncture may be up to 6 treatments to confirm functional improvement. Acupuncture treatments may be extended only if true functional improvement is documented as defined in Section 9792.20(f). It is an adjunct and usually performed after other conservative measures, such as physical therapy. The patient just commenced therapy, and it is not clear the therapy was not tolerated or not successful. Adding acupuncture is premature. The sessions were appropriately not medically necessary under the MTUS Acupuncture criteria.

Initial functional captivity evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines FCE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 Chronic Pain Guidelines Page(s): 48.

Decision rationale: Chronic Pain Medical Treatment guidelines, page 48 note that a functional capacity evaluation (FCE) should be considered when necessary to translate medical impairment into functional limitations and determine return to work capacity. There is no evidence that this is the plan in this case. The MTUS also notes that such studies can be done to further assess current work capability. However, there is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace; an FCE reflects what an individual can do on a single day, at a particular time, under controlled circumstances, that provide an indication of that individual's abilities. Little is known about the reliability and validity of these tests and more research is needed The ODG notes that several criteria be met. I did in this case find prior unsuccessful return to work attempts, or the cases, relation to being near a Maximal Medical Improvement declaration. Initial or baseline FCEs are not mentioned, as the guides only speak of them as being appropriate at the end of care. The case did not meet this timing criterion. For these reasons, this request was appropriately not medically necessary.

Cardio respiratory diagnostic testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Zipes Braunwald's Heart Disease 7th Ed Chapter 10.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.mdguidelines.com/electrocardiogram.

Decision rationale: The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. Cardiorespiratory diagnostic testing is a broad descriptive term. It is no precisely known what tests make up the request. Per the Medical Disability Advisor citation, the ECG (also known as EKG) is essential in the diagnosis of various disease conditions of the heart, including coronary artery disease (angina and heart attack), disturbances in heart rhythm (arrhythmias), disturbances in electrical conduction (heart blocks), thickening of the heart muscle, or acute inflammation of the membrane that covers the heart (acute pericarditis). It can be used to determine whether heart damage is due to a recent heart attack (myocardial infarction) or an old one. The procedure is commonly performed during routine periodic physical examination. In this case, there is no chest pain of a cardiac nature, and no cardiac issues. The clinical necessity of doing this test is not apparent from the medical records provided. This request is appropriately not certified as being clinically necessary for the claimant's condition. In addition, pulmonary function tests are also used to assess the cardio respiratory system. In this case, there is no chest pain of a cardiac nature, and no cardiac issues. The clinical necessity of doing this test is not apparent from the medical records provided. This request is appropriately not medically necessary as being clinically necessary for the claimant's condition.