

Case Number:	CM14-0092101		
Date Assigned:	09/19/2014	Date of Injury:	04/27/2010
Decision Date:	10/17/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/18/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 is a 43-year-old male with a 4/27/10 date of injury, when he was unloading a heavy gym material and sustained injuries to his neck and the right shoulder. The patient underwent distal clavicle resection in 2011 and the right shoulder arthroscopy in 2013. The progress notes indicated that the patient was attending FRP and on 6/19/14 his pain in the cervical spine, in the right shoulder, elbow and wrist was 8/10, and the patient's pain on 7/11/14 was still 8/10 with mild improvement in the wrist pain that was 6/10. The patient was seen on 8/19/14 with complaints of 8/10 neck pain radiating down to the right hand; 8/10 right shoulder pain and 8/10 right elbow pain. The patient did not participate in any activities to his pain. Exam findings of the cervical spine revealed tenderers over right paraspinal muscles and right trapezius muscle with decreased sensation over C6-T1 dermatome distributions. The muscle strength of the shoulders was 4/5 on the right and 5/5 on the left. The right hand grip Jamar testing was 8-8-10 and the left hand grip Jamar testing was 52-52-52. The range of motion in the right shoulder was decreased due to pain and the impingent test and Neer's test were positive on the right. The diagnosis is shoulder impingement, status post 2 right shoulder surgeries, right elbow/wrist/shoulder sprain/strain. Treatment to date: physical therapy, work restrictions, medications, An adverse determination was received on 6/6/14. The requested to compound topical medication was denied given that the specific components of the topical compound medication have not been provided. The request for FRP was denied given that the requested program was actually a comprehensive multidisciplinary program as opposed to simply a continuation of conservative therapies such as PT and acupuncture. The request for Acupuncture was denied given that there was a lack of documentation indicating objective evidence of improvement from previous acupuncture treatments. The request for computerized range of motion and muscle strength testing was denied given that there was no evidence to confirm that

the patient's condition reached permanent and stationary level where this testing could be appropriate.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compound Medication (individual components not provided): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Capsaicin, Topical Analgesics Page(s): 25, 28, 111-113.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is a lack of documentation specifying the ingredients of the compound medication and there is no rationale with regards to the area of the application and the specified goals from the treatment. Therefore, the request for Compound Medication was not medically necessary.

Functional Restoration Program (FRP) 2x6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the general use of multidisciplinary pain management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 31-32.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines criteria for functional restoration program participation include an adequate and thorough evaluation; previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; a significant loss of ability to function independently; that the patient is not a candidate where surgery or other treatments would clearly be warranted; that the patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; and that negative predictors of success above have been addressed. CA MTUS Chronic Pain Medical Treatment Guidelines support continued FRP participation with demonstrated efficacy as documented by subjective and objective gains. Additionally, MTUS states that total treatment duration should generally not exceed 20 sessions without a clear rationale for the specified extension and reasonable goals to be achieved. The progress notes indicated that the patient attended FRP. However, the number of visits is unclear. The comparison in the patient's pain levels from 6/19/14 and 7/11/14 revealed only minimal improvement in the patient's wrist pain. There is a lack of documentation

indicating objective functional gains from the treatment and there is no rationale with regards to continuation of FRP. Therefore, the request for Functional Restoration Program (FRP) 2x6 weeks was not medically necessary.

Acupuncture x 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Pain, Suffering, and the Restoration of Function Chapter (page 114)

Decision rationale: CA MTUS/ACOEM guidelines stress the importance of a time-limited treatment plan with clearly defined functional goals, with frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician is paramount. In addition, Acupuncture Medical Treatment Guidelines state that acupuncture may be used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Furthermore, guidelines state that time to produce functional improvement of 3 - 6 treatments. It is not clear if the patient underwent acupuncture treatment in the past and there is no clear rationale indicating what body parts should be treated. Therefore, the request for Acupuncture x 12 was not medically necessary.

Range of Motion and Muscle Testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Flexibility; Aetna Policy, Quantitative Muscle Testing Devices; Regence Group, Quantitative Muscle Testing Devices, Policy # MED.00089, 01/13/2010

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation X Official Disability Guidelines (ODG) Low Back Chapter, Computerized ROM Testing

Decision rationale: CA MTUS does not address this issue. ODG states that flexibility should be a part of a routine musculoskeletal evaluation, and does 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. The AMA Guides to the Evaluation of Permanent Impairment, 5th edition, state, "an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical and inexpensive way". The patient underwent musculoskeletal evaluation during the orthopedic evaluation dated 8/19/14. There is no rationale with clearly specified goals with regards to the Range of Motion and Muscle Testing. Therefore, the request for the Range of Motion and Muscle Testing was not medically necessary.

