

Case Number:	CM14-0211999		
Date Assigned:	01/02/2015	Date of Injury:	06/23/2014
Decision Date:	02/27/2015	UR Denial Date:	11/19/2014
Priority:	Standard	Application Received:	12/18/2014

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. 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 & Rehabn

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 patient is a 47-year-old male with date of injury of 06/23/2014. The listed diagnoses from 11/06/2014 are 1. Lumbar spine sprain/strain 2. Myospasms 3. Bilateral shoulder rain/strain 4. Clinical impingement 5. Bilateral wrist sprain/strain 6. Lumbar radiculitis 7. Chronic pain 8. Right shoulder impingement syndrome 9. Left shoulder impingement syndrome 10. Left wrist subchondral bone cyst of the 3rd metacarpal bone 11. Left wrist lunate bone cyst 12. Right hand subchondral bony cyst at the 3rd metacarpal bone 13. Right hand 4th metacarpal tenosynovitis 14. Left hand subchondral cyst of the head of the 3rd metacarpal 15. Lumbar spine multilevel disk protrusion 16. Lumbar spine facet hypertrophy 17. Anxiety 18. Insomnia. According to this report, the patient complains of bilateral wrist, bilateral hand, shoulder, and low back pain. He is experiencing mild to moderate pain in his hands and he notes moderate to severe pain in his low back. The patient has insomnia secondary to pain. Examination shows decreased range of motion in the lumbar spine. Positive facet loading throughout the lumbar spine and straight leg raise bilaterally. Deep tendon reflexes are +2/4. Range of motion in the bilateral shoulders is decreased. Positive impingement, Neer's sign, and Hawkins' sign. There is decreased range of motion in his bilateral wrist with tenderness over the dorsum in the radius of the wrist and of the palm and the volar and dorsal aspects of the finger. Decreased grip strength bilaterally. Pulses are +2/4. He has full range of motion of all his fingers. Treatment reports from 06/23/2014 to 11/10/2014 were provided for review. The utilization review denied the request on 11/19/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

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, Low Back - Lumbar & Thoracic (Acute & Chronic), Range of Motion (ROM)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter on functional improvement measures.

Decision rationale: This patient presents with bilateral wrist, bilateral hand, shoulder, and low back pain. The treater is requesting RANGE OF MOTION AND MUSCLE TESTING. The MTUS and ACOEM Guidelines do not address this request; however, ODG under the pain chapter on functional improvement measures states that it is recommended. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. The following category should be included in this assessment including Work function and/or activities of daily living, physical impairments, approach to self-care and education. In this case, ODG does recommend range of motion testing and muscle testing as part of follow up visit and routine examination. However, it is not recommended as a separate billable service. The request IS NOT medically necessary.

Supervised Functional Restoration Program: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic), Functional Restoration Program

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs Page(s): 30-32.

Decision rationale: This patient presents with bilateral wrist, bilateral hand, shoulder, and low back pain. The treater is requesting is requesting a SUPERVISED FUNCTIONAL RESTORATION PROGRAM. The MTUS Guidelines page 30 to 32 recommends Functional Restoration Programs when all of the following criteria are met including 1. Adequate and thorough evaluation has been made 2. Previous methods of treating chronic pain had been unsuccessful 3. Significant loss of the ability to function independently resulting from chronic pain 4. Not a candidate for surgery or other treatments would clearly be warranted 5. The patient exhibits motivation change 6. Negative predictor of success above has been addressed. These negative predictors include evaluation for poor relationship with employer, work satisfaction, negative outlook in the future, etc. The records show 2 functional restoration reports from 11/10/2014 and 11/12/2014. It would appear

that the treater went ahead and authorized the Functional Restoration Program before the UR denied it on 11/19/2014. None of the reports discuss the required criteria by MTUS for admission to a Functional Restoration Program. The request IS NOT medically necessary.

Acupuncture: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13.

Decision rationale: This patient presents with bilateral wrist, bilateral hand, shoulder, and low back pain. The treater is requesting ACUPUNCTURE. The MTUS Guidelines for acupuncture states that it is 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. In addition, MTUS states that an initial trial of 3 to 6 visits is recommended. Treatment may be extended if functional improvement is documented. The records do not show any acupuncture therapy reports. The 11/06/2014 report notes that the treater is requesting 12 acupuncture sessions for this patient. In this case, while a trial may be appropriate for this patient, the requested 12 exceeds MTUS recommended 4 to 6 initial visits and the current IMR request is for an unlimited quantity for an unlimited duration. The request IS NOT medically necessary.