

Case Number:	CM15-0010409		
Date Assigned:	01/28/2015	Date of Injury:	05/13/2014
Decision Date:	03/18/2015	UR Denial Date:	01/10/2015
Priority:	Standard	Application Received:	01/20/2015

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 66 year old male, who sustained an industrial injury on May 13, 2014. The diagnoses have included arm pain, biceps tendonitis, ruptured biceps tendon due to trauma, chronic pain due to trauma and radial nerve injury. Treatment to date has included distal biceps tendon reattachment, distal biceps repair using biceps button and tension slide technique on 6/23/2014, post-operative physical therapy and pain medication. Currently, the injured worker complains of musculoskeletal pain of the right arm with radiation of pain to the right arm. The pain is moderate-severe, burning, sharp, numbing and discomforting. The pain is relieved with heat and ice. The injured worker rated the pain without medications a 6 on a 10-point scale. On examination, the injured worker had excellent range of motion; however, the injured worker expressed concerns that his arm is too weak, that it goes numb when he has prolonged sitting and he would not be able to go back to his regular line of work. He is strict and conscientious with his home exercise program. The evaluating physician noted safety issues related to returning the injured worker with an old full biceps rupture and a damaged radial nerve at the wheel of an 18-wheeler traveling between the injured worker's workplace and ██████████ for 12 - 13 hours per day in cold weather. On January 10, 2015 Utilization Review non-certified a request for one physical therapy consultation, one functional capacity evaluation and one EMG/NCV, noting that the injured worker completed 24 sessions of post-operative physical therapy with full motion has returned to the elbow and the participation in a home exercise program, no effort at return to work, no conflicting medical reporting regarding precautions and/or fitness for modified work, no evidence the treating provider has evaluated the injured worker's job duties, and reports of

improvement in the forearm and stable sensory findings. The California Medical Treatment Utilization Schedule and Official Disability Guidelines were cited. On January 20, 2015, the injured worker submitted an application for IMR for review of one physical therapy consultation, one functional capacity evaluation and one EMG/NCV.

IMR ISSUES, DECISIONS AND RATIONALES

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

One physical therapy consultation: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: According to MTUS guidelines, Physical Medicine is 'Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007). 'There is no documentation of objective findings that support musculoskeletal dysfunction requiring more physical therapy. There is no documentation of outcome of previous physical therapy sessions. There is no documentation of objective neurologic and muscular skeletal deficits requiring more physical therapy Therefore, the request for one physical therapy consultation is not medically necessary.

One functional capacity evaluation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Functional capacity evaluation (FCE)

Decision rationale: According to ODG guidelines, <http://www.odg-twc.com/> Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. Not recommend routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally. 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 [REDACTED] 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) [REDACTED] 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 evaluatee complains of evaluator bias, lack of expertise, or poor professional conduct, the FCE can be considered useless. (Genovese, 2009) Recent research: An RCT compared FCEs using a well-known protocol, the proprietary [REDACTED] ([REDACTED]) FCE ([REDACTED]), with functional interviews conducted by specially trained FCE clinicians (collecting self-report information only, but no measurements). Even though those who had an FCE were found to have higher work capacity than those who were interviewed, it made no difference to the outcome.

RTW results were the same whether the injured worker's capability had been assessed using a full two-day FCE, or a much shorter interview by an expert listener. The authors concluded that FCE does not appear to enhance outcomes (improved RTW rates or functional work levels at follow-up) when integrated into the process of occupational rehabilitation. (Gross, 2013) Guidelines for performing an FCE: Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. 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) There is no documentation that the patient is considered for admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. It seems that the evaluation is more for a routine use as part of occupational rehab or screening. Therefore, the request is not medically necessary.

One EMG/NCV: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 33.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269.

Decision rationale: According to MTUS guidelines (MTUS page 303 from ACOEM guidelines), 'Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks.' EMG has excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. "When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study Electromyography (EMG), and nerve conduction velocities (NCV), 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" (page 178). EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain (page 179). There is no documentation of peripheral nerve damage, cervical radiculopathy and entrapment neuropathy that requires electrodiagnostic testing. There is no documentation of significant change in the patient condition. Therefore, the request for One EMG/NCV is not medically necessary.

