

<b>Case Number:</b>	CM15-0175482		
<b>Date Assigned:</b>	10/09/2015	<b>Date of Injury:</b>	03/18/2010
<b>Decision Date:</b>	12/11/2015	<b>UR Denial Date:</b>	08/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2015

### 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: 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:

This is a 62-year-old male with a date of industrial injury 3-18-2010. The medical records indicated the injured worker (IW) was treated for lumbar disc protrusion; lumbar radiculopathy; sprain of the sacroiliac joint, left; left rotator cuff tear; left shoulder bursitis; left shoulder impingement syndrome; right hip sprain-strain; right knee chondromalacia; right knee internal derangement; right knee severe degenerative joint disease. In the progress notes (7-16-15), the IW reported constant pain in the low back, the left shoulder, the right and left hip and the right knee. He was taking Oxycodone 10mg twice daily as needed for pain (since about 6-2015); improvement in pain and function was not documented. On examination (7-16-15 notes), the IW weighed 247 pounds, which was a 50-pound weight gain since the original injury; height and BMI were not documented. He walked with a cane. Motor strength was 4 out of 5 bilaterally in the upper and lower extremities and deep tendon reflexes were normal and equal bilaterally at 2 out of 2. The left sacroiliac joint, lumbar paravertebral muscles, left shoulder, anterior right hip, left hip and right knee were tender to palpation. Spasms were present in the lumbar paravertebrals, anterior and posterior left shoulder, right and left hip and anterior and posterior right knee. Straight leg raise was positive bilaterally. Ranges of motion were less than normal in the lumbar spine, left shoulder and right knee. Neer's and Hawkins' signs were positive in the left shoulder; Patrick's FABERE was positive in the left hip; and McMurray's sign was positive in the right knee. Treatments included physical therapy, which was not helpful (4-7-15 notes), shockwave therapy for the right knee, which made his symptoms worse (6-2-15 notes); acupuncture for the left shoulder; cortisone injections for the right knee; and home exercise. The

IW was temporarily totally disabled. A Request for Authorization was received for a 30-day trial of a [REDACTED] program; one functional capacity evaluation; Oxycodone 10mg, #60; trigger points impedance imaging; unknown sessions of extracorporeal shockwave therapy; and unknown localized intense neurostimulation therapy. The Utilization Review on 8-4-15 non-certified the request for a 30-day trial of a [REDACTED] program; one functional capacity evaluation; Oxycodone 10mg, #60; trigger points impedance imaging; unknown sessions of extracorporeal shockwave therapy; and unknown localized intense neurostimulation therapy.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**[REDACTED] program (30-day trial): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pharmacologic and surgical management of obesity in primary care: a clinical practice guideline from the American College of Physicians.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Weight Reduction Medications and Programs, Number: 0039, last reviewed: 03/21/2014.

**Decision rationale:** The MTUS and the Official Disability Guidelines are silent on the topic of medical weight loss programs. The Aetna Clinical Policy Bulletin: Weight Reduction Medications and Programs was referenced in regard to the request. This policy is supported by NHLBI Guidelines on Diagnosis and Management of Obesity. Aetna considers the following medically necessary treatment of obesity when criteria are met: 1. Weight reduction medications, and 2. Clinician supervision of weight reduction programs. The request does not contain documentation that the above criteria are met. Therefore, the request is not medically necessary.

**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.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness For Duty, Functional capacity evaluation (FCE).

**Decision rationale:** The Official Disability Guidelines state that a functional capacity evaluation is appropriate if, case management is hampered by complex issues and the timing is appropriate; such as if the patient is close to being at maximum medical improvement or additional clarification concerning the patient's functional capacity is needed. Functional capacity evaluations are not needed if the sole purpose is to determine a worker's effort or compliance, or the worker has returned to work. There is no documentation in the medical record to support a functional capacity evaluation based on the above criteria. Therefore, the request is not medically necessary.

**Oxycodone 10mg, #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**Decision rationale:** The MTUS recommends Oxycodone for moderate to moderately severe pain. Opioids for chronic pain appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear, but also appears limited. If the patient does not respond to a time-limited course of opioids, it is suggested that an alternate therapy be considered. For the on-going management of opioids there should be documentation of pain relief, functional improvement, appropriate use and side effects. There was no documentation of functional improvement with the continued use of Oxycodone. Therefore, the request is not medically necessary.

**Trigger Points Impedance Imaging: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections.

**Decision rationale:** According to the CA MTUS Guidelines, trigger point injections, with a local anesthetic, may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. The documentation fails to meet the above criteria. Trigger point injections are not medically necessary; consequently, an imaging method to locate the trigger points is not medically necessary. Therefore, the request is not medically necessary.

**Extracorporeal shockwave therapy: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Extracorporeal shock wave therapy (ESWT).

**Decision rationale:** Extracorporeal shock wave therapy is not recommended by the guidelines. Limited evidence exists regarding extracorporeal shock wave therapy (ESWT) in reducing pain and improving function. While it appears to be safe, there is disagreement as to its efficacy. Insufficient high quality scientific evidence exists to determine clearly the effectiveness of this therapy. Therefore, the request is not medically necessary.

**Localized intense neurostimulation therapy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Localized intense neurostimulation therapy (LINT), Pain (Chronic), Percutaneous electrical nerve stimulation (PENS).

**Decision rationale:** Localized Intense Neurostimulation Therapy (LINT) is equivalent to Percutaneous Electrical Nerve Stimulation (PENS). The Official Disability Guidelines do not recommend percutaneous electrical nerve stimulation as a primary treatment modality. There is a lack of high quality evidence to prove long-term efficacy. A trial may be considered, if used as an adjunct to a program of evidence-based functional restoration, after other non-surgical treatments, including therapeutic exercise and TENS, have been tried and failed or are judged to be unsuitable or contraindicated. Therefore, the request is not medically necessary.