

Case Number:	CM15-0034108		
Date Assigned:	03/27/2015	Date of Injury:	11/01/2012
Decision Date:	06/05/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	02/24/2015

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: Pennsylvania

Certification(s)/Specialty: Internal 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 60 year old female who has reported widespread pain of gradual onset attributed to usual work activity, with a listed injury date of 11/1/12. She has reported pain in the neck, back, shoulders, and upper extremities. The diagnoses have included cervical disc protrusion, radiculitis, thoracic myofascitis, thoracic sprain/strain, lumbar disc protrusion, rotator cuff tear, shoulder internal derangement, lateral epicondylitis, carpal tunnel syndrome and hand joint pain. Treatment to date has included medications, physical therapy, acupuncture and shockwave treatment. The medical records do not contain any records of treatment prior to 12/17/14. The injured worker was seen for an initial evaluation on 12/17/14. There was neck, back, shoulder, and upper extremity pain. She was not working at her prior employer. There was no discussion of any prior treatment or the clinical course of the conditions since the date of injury. The physical exam was inclusive of tenderness, painful and limited range of motion. The treatment plan listed the items now referred for Independent Medical Review, with no specific rationale for any of the items. The transcutaneous nerve stimulation/electronic muscle stimulation (TENS/EMS) was for a rental of no duration. The extracorporeal shock wave therapy (ESWT) was for the neck and back. Physical therapy was for all the painful areas, 12 visits. The work status was "temporarily totally disabled." There was no rationale for the "MD consult." The Request for Authorization of 12/17/14 contains the items now referred for Independent Medical Review. The electrical stimulation request was for a TENS/EMS. ESWT did not include any body parts, frequency, or duration. The listed diagnoses for ESWT were for the back and neck. Work status was temporarily totally disability. Per the 2/17/15 Utilization Review letter, a

psychological evaluation and radiographs of the wrists, shoulders, neck, and back were certified. Radiographs of the hands and elbows, a lumbar brace, ESWT, Voltage-Actuated Sensory Nerve Conduction Threshold (VSNCT), MRIs, a functional capacity evaluation, a TENS rental, physical therapy, and acupuncture were non-certified. The MTUS, the Official Disability Guidelines, and other literature were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non- MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 1 Prevention Page(s): 9, 308. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM Guidelines, Update 4/7/08, Low Back Chapter, page 138, lumbar supports.

Decision rationale: The ACOEM Guidelines do not recommend lumbar binders, corsets, or support belts as treatment for low back pain, see page 308. On Page 9 of the Guidelines, "The use of back belts as lumbar support should be avoided because they have been shown to have little or no benefit, thereby providing only a false sense of security." The updated ACOEM Guidelines likewise do not recommend lumbar braces for treatment of low back pain. The lumbar brace is therefore not medically necessary.

X-ray bilateral hands: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non- MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 254-258, 268-269.

Decision rationale: The ACOEM Guidelines pages 254-258 list the criteria for examining the hand and wrist. The necessary components of the examination are not present. The specific historical details of any wrist symptoms are not described sufficiently. Per Page 268-269 of the ACOEM Guidelines, special studies are not needed until after a 4-week period of conservative care. Common tests are listed, with indications. Specific care for the wrist was not described adequately. The treating physician has not provided sufficient indications for any imaging test. The radiographs are not medically necessary based on the lack of sufficient indications and the cited guidelines.

X-ray bilateral elbow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: Per the ACOEM Guidelines for the Elbow, Page 33, Special Studies and Diagnostic and Treatment Considerations, criteria for ordering imaging studies are: The imaging study results will substantially change the treatment plan. Emergence of a red flag. Failure to progress in a rehabilitation program, evidence of significant tissue insult or neurological dysfunction that has been shown to be correctible by invasive treatment, and agreement by the patient to undergo invasive treatment if the presence of the correctible lesion is confirmed. The treating physician has not provided evidence of a red flag condition, a surgical condition, or discussed the failure of a specific rehabilitative program. The tests are therefore not medically necessary.

Extracorporeal Shock Wave Therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Peer Review Literature.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, Shock wave therapy.

Decision rationale: This request does not list any body part. The reports suggest that ESWT was intended for the spine. The MTUS does not provide direction for shock wave therapy for low back pain. The Official Disability Guidelines cited above recommend against this therapy. It is therefore not medically necessary.

Voltage-Actuated Sensory Nerve Conduction Threshold: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck chapter, Pain chapter, Current perception threshold (CPT) testing, Sensory nerve conduction threshold (sNCT) device.

Decision rationale: This electrodiagnostic testing was not prescribed for any specific body part. The request and prescription are therefore not sufficient for the purposes of medical necessity. The treating physician has provided no specific indications for this test. The MTUS does not provide direction for the use of VsNCT, CPT tests, or the other similar tests. The Official Disability Guidelines recommend against these kinds of tests, noting the lack of medical evidence. This test is therefore not medically necessary.

MRI bilateral shoulders: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209, 200.

Decision rationale: The MTUS-ACOEM Guidelines, pages 207-9, discuss the criteria for imaging of the shoulder. Special studies are not needed unless there has been a 4-6 week period of conservative care. Exceptions to this rule include the specific bony pathology listed on page 207, and neurovascular compression. Page 200 of the ACOEM Guidelines describes the components of the clinical evaluation of the shoulder. The necessary components of the shoulder examination described in the MTUS are not present. The available reports do not adequately explain the kinds of conservative care already performed. The treating physician has not provided sufficient evidence in support of likely intra-articular pathology or the other conditions listed in the MTUS. The MRI is not medically necessary based on the MTUS recommendations.

MRI Lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 291-296, 303-305, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, MRI.

Decision rationale: The treating physician has not described the clinical evidence of significant pathology discussed in the MTUS, such as "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination." No 'red flag' conditions are identified. The treating physician has not provided an adequate clinical evaluation, as outlined in the MTUS ACOEM Guidelines Pages 291-296. Per the Official Disability Guidelines citation above, imaging for low back pain is not beneficial in the absence of specific signs of serious pathology. The treating physician has not provided specific indications for performing an MRI. This patient does not fit the MTUS criteria for invasive procedures, such as epidural steroid injection or spine surgery, regardless of any proposed MRI findings. MRI of the lumbar spine is not indicated in light of the paucity of clinical findings suggesting any serious pathology; increased or ongoing pain, with or without radiation, is not in itself indication for MRI. An MRI of the lumbar spine is not medically necessary based on lack of sufficient indications per the MTUS and the Official Disability Guidelines.

Functional Capacity Exam: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 81, Chronic Pain Treatment Guidelines Work conditioning, work hardening Page(s): 126. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty chapter, Functional capacity evaluation and Other Medical Treatment Guidelines.

Decision rationale: The ACOEM guidelines pages 137-8, in the section referring to Independent Medical Evaluations (which is not the context in this case), state "there is little scientific evidence confirming that functional capacity evaluations predict an individual's actual capacity to perform in the workplace" and "It is problematic to rely solely upon the functional capacity evaluation results for determination of current work capability and restrictions." The MTUS for Chronic Pain and the Official Disability Guidelines recommend a

functional capacity evaluation for Work Hardening programs, which is not the context in this case. The Official Disability Guidelines state that a functional capacity evaluation is "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." The current request does not meet this recommendation, as it appears to be intended for general rather than job-specific use. The treating physician has not defined the components of the functional capacity evaluation. Given that there is no formal definition of a functional capacity evaluation, and that a functional capacity evaluation might refer to a vast array of tests and procedures, medical necessity for a functional capacity evaluation (assuming that any exists), cannot be determined without a specific prescription which includes a description of the intended content of the evaluation. The MTUS for Chronic Pain, in the Work Conditioning-Work Hardening section, mentions a functional capacity evaluation as a possible criterion for entry, based on specific job demands. The treating physician has not provided any information in compliance with this portion of the MTUS. The functional capacity evaluation in this case is not medically necessary based on lack of medical necessity and lack of a sufficiently specific prescription.

TENS Unit rental: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices), TENS, chronic pain Page(s): 121, 114-117.

Decision rationale: The MTUS recommends against EMS for chronic pain. No physician reports address the specific medical necessity for a TENS unit. The MTUS for Chronic Pain lists the indications for TENS, which are primarily neuropathic pain, a condition not present in this patient. Other recommendations, including specific components of the treatment plan, are listed in the MTUS. The necessary kind of treatment plan is not present, including a focus on functional restoration with a specific trial of TENS alone. Given the lack of clear indications in this injured worker (primary reason), and the lack of any clinical trial or treatment plan per the MTUS (secondary reason), a TENS/EMS unit is not medically necessary.

Physiotherapy 2 x 6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, functional improvement, Physical Medicine Page(s): 9, 98-99.

Decision rationale: The treating physician has not provided an adequate request for this service, which must contain diagnosis, duration, frequency, and treatment modalities, at minimum. Per the MTUS, Chronic Pain section, functional improvement is the goal rather than the elimination of pain. The maximum recommended quantity of Physical Medicine visits is 10, with progression to home exercise. The treating physician has not stated a purpose for the current physical therapy prescription. It is not clear what is intended to be accomplished

with this physical therapy, given that it will not cure the pain and there are no other goals of therapy. The current physical therapy prescription (12 visits) exceeds the quantity recommended in the MTUS (10 visits). No medical reports identify specific functional deficits, or functional expectations for Physical Medicine. The Physical Medicine prescription is not sufficiently specific, and does not adequately focus on functional improvement. The "temporarily totally disabled" work status is evidence of a lack of focus on functional improvement. Given the completely non-specific prescription for physical therapy in this case, it is presumed that the therapy will use passive modalities. Note that the MTUS recommends against passive modalities for treating chronic pain. Physical Medicine is not medically necessary based on the MTUS, lack of sufficient emphasis on functional improvement, the insufficient prescription, and the excessive number of visits.

Acupuncture 1 x 6: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Per the MTUS, acupuncture 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. The treating physician has not provided the specific indications for acupuncture as listed in the MTUS. There is no discussion of issues with pain medications, or functional recovery in conjunction with surgery and physical rehabilitation. Given that the focus of acupuncture is functional improvement, function (including work status or equivalent) must be addressed as a starting point for therapy and as a measure of progress. "Temporarily totally disabled" work status is evidence of a lack of focus on functional improvement. As discussed in the MTUS, chronic pain section, the goal of all treatment for chronic pain is functional improvement, in part because chronic pain cannot be cured. A course of acupuncture is not medically necessary based on the lack of specific indications per the MTUS and the lack of focus on functional improvement.