

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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April 26, 2013

**Notice of Standard Independent Medical Review Determination
MAXIMUS Case No. CM13-000040**

[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

Determination: MAXIMUS Federal Services, Inc. has determined the requested physical therapy three times a week for four weeks; X-ray of cervical spine; and X-ray of left elbow **are medically necessary**. MAXIMUS Federal Services, Inc. has also determined the requested functional capacity evaluation and computerized range of motion/muscle test are **not medically necessary**.

A request for a(n) standard Independent Medical Review was filed with the Administrative Director, Division of Workers' Compensation. The case was assigned to MAXIMUS Federal Services as the designated Independent Medical Review Organization.

Medical Qualifications of Professional Reviewer: The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, with a subspecialty certificate in Pain Medicine, 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 per week in active practice. The

professional 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 treatments and/or services at issue.

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated February 6, 2013

“PR-2 dated 1/30/13 indicates that the claimant complains of left arm pain that radiates to the shoulder down to the hand with numbness and tingling from the elbow into the hand. The claimant reports left-sided neck spasms [that radiate] to the upper back at times. The provider recommends physical therapy 3 times per week for 4 weeks for the left elbow, left shoulder, left knee and thoracic spine, functional capacity evaluation, x-ray, Tramadol 50 mg 1 by mouth 3 times per day #90, and computerized range of motion/muscle testing. The claimant is on modified work with restrictions.

Doctor’s first report of occupational injury or illness dated 01/30/13 indicates that the claimant developed pain in the neck, left shoulder, left elbow and upper back between 09/01/11-01/01/13, which attributed to lifting folders. The claimant complains of frequent neck pain, which radiates to the neck and left side of the head. Claimant complains of frequent left shoulder pain, which radiates to the neck and left arm. Claimant also complains of frequent left elbow pain and intermittent upper back pain. On exam, there is tenderness along the left upper trapezius muscles and acromioclavicular joint. Impingement and drop-arm tests are positive. There is tenderness along the left olecranon bursa. The provider recommends x-rays of the neck and left elbow, Tramadol, computerized range of motion and physical thereapy for the left elbow, left shoulder, left neck and thoracic spine 3 times per week for 4 weeks. The claimant is placed on modified work with restrictions.”

Documents Reviewed for Determination:

The interested parties were notified that the review was assigned on a standard basis. The relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for IMR
- Explanation of Utilization Review by [REDACTED] (Excel) (dated 2/6/13)
- Utilization Review by [REDACTED] (dated 2/6/13)
- Explanation of Utilization Review by [REDACTED] (dated 4/17/13)
- Employee’s Medical Records from [REDACTED] (dated 1/24/13 through 1/29/13)
- Doctor’s First Report of Occupational Injury or Illness signed by [REDACTED] (dated 1/25/13)
- Primary Treating Physician’s Initial Comprehensive Report and Request for Authorization of Treatment by [REDACTED] (dated 1/30/13)
- Doctor’s First Report of Occupational Injury or Illness signed by [REDACTED] (dated 1/30/13)

- Employee's Medical Records from [REDACTED] (dated 2/25/13 through 4/4/13)
- ACOEM – Chapters 8, 9, 10, and 12

Professional Reviewer's Rationale Regarding the Following Treatment Requests:

1. Physical Therapy
2. Functional Capacity Evaluation
3. Computerized Range of Motion/Muscle Testing
4. X-ray of Cervical Spine
5. X-ray of Left Elbow

1. Physical Therapy

Medical Treatment Guideline(s) Relied Upon by the MAXIMUS Professional Reviewer:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (2009). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the evidence-based criteria used by the Claims Administrator appropriate for the clinical circumstance.

MAXIMUS Professional Reviewer's Rationale:

With regard to the request for physical therapy, Official Disability Guidelines specify a recommended course of 10 visits of physical therapy for cervical sprains and strains, 14 visits of physical therapy for elbow sprains and strains, and 10-12 visits of physical therapy for shoulder injuries. This injured worker has reasonable suspicion for cumulative trauma disorder related to work. The timeframe of this cumulative trauma disorder was from September 2011 through January 2013. Given that the pain has persisted for a long duration, a full trial of physical therapy is warranted. The recommendation for a full course of physical therapy consisting of 12 visits, three times a week for four weeks is medically necessary.

2. Functional Capacity Evaluation

Medical Treatment Guideline(s) Relied Upon by the MAXIMUS Professional Reviewer:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, 2004 and ODG. The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the evidence-based criteria used by the Claims Administrator appropriate for the clinical circumstance.

MAXIMUS Professional Reviewer's Rationale:

With regard to the request for a functional capacity evaluation (FCE), the California Medical Treatment Utilization Schedule specifies that FCEs are not recommended. The

scientific literature regarding the usefulness of FCEs is sparse. The ACOEM guidelines state that a functional capacity evaluation should be considered when necessary to translate medical impairment into functional limitations indeterminate work if abilities. The Official Disability Guidelines specify that the following criteria should be met for consideration of an FCE:

1. Case management is hampered by complex issues such as previous and successful return to work at temps or conflicting medical reporting on precautions and or fitness for modified job.
2. Timing should be appropriate and the patient should be at or close to maximum medical improvement, with all secondary conditions clarified. Furthermore, the ODG that specifies that FCE's should not take place if the worker has returned to work and an ergonomic assessment has not been arranged.

In the case of this injured worker, there does not appear to be any previous failed attempts to return to work. At this juncture, an FCE is premature as the patient has not reached MMI according to the documentation. The patient has yet to complete a full course of physical therapy. This request is not medically necessary.

3. Computerized Range of Motion / Muscle Test

Medical Treatment Guideline(s) Relied Upon by the MAXIMUS Professional Reviewer:

The Claims Administrator based its decision on ACOEM and Dopf et al.¹ The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the evidence-based criteria used by the Claims Administrator appropriate for the clinical circumstance.

MAXIMUS Professional Reviewer's Rationale:

With regard to the request for computerized range of motion testing, California MTUS does not have any provisions for computerized range of motion testing. However, as per section 9792.21, treatment is not denied solely on the basis of no specific recommendations. In cases where the California MTUS does not have specific provisions, evidence-based national standards of care are applied instead. Computerized range of motion testing is not considered standard of care. The evidence is lacking for this diagnostic procedure. In a study by Dopf et al, there is a small study indicating less variability when computerized ROM testing was done versus non-computerized measurements, but the superiority or indications for such computerized measurements was not established. Given the guidelines, this request is not medically necessary.

¹ ACOEM includes a discussion of Dopf CA, Mandel SS, Geiger DF, Mayer PJ. Analysis of spine motion variability using a computerized goniometer compared to physical examination. A prospective clinical study. Spine (Phila Pa 1976). 1994 Mar 1;19(5):586-95. PMID 8184354

4. Cervical Spine X-ray

Medical Treatment Guideline(s) Relied Upon by the MAXIMUS Professional Reviewer:

The Claims Administrator based its decision on ACOEM and ODG. The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the evidence-based criteria used by the Claims Administrator appropriate for the clinical circumstance.

MAXIMUS Professional Reviewer's Rationale:

With regard to the request for cervical X-ray, the Official Disability Guidelines specify the following conditions for which cervical spine X-rays are warranted:

1. Cervical spine trauma
2. Chronic neck pain with a history of remote trauma
3. Chronic neck pain, patient older than 40 years old, no history of trauma, first study.
4. Chronic neck pain history of previous malignancy or remote neck surgery for study
5. Post-surgery to evaluate the status of fusion.

In the case of this injured worker, there has been an industrially related neck pain that has developed due to repetitive strain. The injured worker is noted to be over 40 years old. Given the chronicity of the symptoms, the cervical spine X-ray for diagnostic purposes is reasonable and this request is medically necessary.

5. Left Elbow X-ray

Medical Treatment Guideline(s) Relied Upon by the MAXIMUS Professional Reviewer:

The Claims Administrator based its decision on ACOEM and ODG. The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found the evidence-based criteria used by the Claims Administrator appropriate for the clinical circumstance.

MAXIMUS Professional Reviewer's Rationale:

With regard to the request for X-ray of the elbow, ACOEM Guidelines specify that special studies for elbow problems are not needed unless at least four weeks of conservative care and observation fails to improve symptoms. The Official Disability Guidelines states that radiography is required before other images studies and maybe diagnostic for osteochondral fracture, osteochondritis dissecans, and osteocartilaginous intra-articular body. In patients with normal extension, flexion, and supination, emergent X-rays are unnecessary.

In the case of this injured worker, physical examination performed by the requesting provider showed positive Tinel's sign at the left elbow. There was tenderness in the area of the olecranon process. Range of motion was noted to be limited with pain. Furthermore, given the chronicity of this patient's elbow complaints over a long time frame of repetitive strain, it is reasonable to obtain plain radiographs prior to starting a full course of physical therapy. This request is medically necessary.

Effect of the decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.