

Case Number:	CM14-0115433		
Date Assigned:	08/04/2014	Date of Injury:	11/16/2012
Decision Date:	09/24/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	07/23/2014

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. The expert reviewer is Board Certified in Occupational 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 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 48-year-old female who has submitted a claim for other specified disorders of bursae and tendons in shoulder region, adhesive capsulitis of shoulder, spondylosis of unspecified site and brachial neuritis or radiculitis, associated with an industrial injury date of November 16, 2012. Medical records from 2013 to 2014 were reviewed. The patient complained of persistent neck, bilateral shoulder and bilateral upper extremity pain, worse on the right. These were accompanied by numbness and burning pain in the right first, second and third digit as well as headaches and difficulty sleeping at night. Current pain medications include anti-inflammatories. Patient previously received physical therapy sessions and has reported benefits from TENS use. Physical examination showed cervical paraspinal muscle spasms and stiffness; limitation of motion of the cervical spine; and tenderness over the right acromioclavicular joint more so than the glenohumeral joint. MRI of the cervical spine dated December 13, 2012 showed moderate to moderately severe right neural foraminal encroachment greatest at C5-6 and to a lesser degree at C6-7 level. The diagnoses were right shoulder rotator cuff tendinitis; bilateral shoulder adhesive capsulitis; cervical degenerative disc disease; possible cervical radiculopathy; and myofascial pain. Treatment to date has included oral and topical analgesics, muscle relaxant, physical therapy, and TENS. Utilization review from July 14, 2014 denied the request for physical therapy 2x4, TENS unit for purchase, and x-ray right shoulder. Reason for denials were not available.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 times per week for 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Preface: Physical Therapy Guidelines.

Decision rationale: According to pages 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. According to ODG, patients should be formally assessed after a "six-visit clinical trial" prior to continuing with the physical therapy. In this case, the patient has received an unspecified number of physical therapy sessions. Response to treatment and body part treatment was directed to were also not discussed. The guideline requires assessment of response after 6 trial visits prior to continuing treatment. The medical necessity has not been established at this time due to limited information. A clear rationale was not provided for continued physical therapy. Therefore, the request for Physical Therapy 2 times per week for 4 weeks is not medically necessary.

TENS (Transcutaneous Electrical Nerve Stimulation) Unit for Purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 2009, Transcutaneous electrotherapy Page(s): 114-116.

Decision rationale: As stated on pages 114-116 of the CA MTUS Chronic Pain Medical Treatment Guidelines, TENS is not recommended as a primary treatment modality. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function and that other ongoing pain treatment should also be documented during the trial period including medication. In this a case, previous TENS use was noted. However, the duration of treatment was not specified. There was also no objective evidence of overall pain improvement and functional gains from its use. The guideline recommends a one-month trial of TENS with documented pain relief and functional improvement prior to continuation of treatment. The medical necessity has not been established. There was no compelling rationale concerning the need for variance from the guideline. Therefore, the request for TENS (Transcutaneous Electrical Nerve Stimulation) Unit for Purchase is not medically necessary.

X-ray Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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

Decision rationale: The CA MTUS ACOEM guidelines state that diagnostic studies are needed when there is a new injury, red flags or a trauma. In this case, most recent progress report do not indicate a new injury, trauma, or red flags of the right shoulder to necessitate plain radiograph. The medical necessity has not been established at this time. There was no clear indication for the request. Therefore, the request for X-ray Right Shoulder is not medically necessary.