

Case Number:	CM14-0163480		
Date Assigned:	11/10/2014	Date of Injury:	05/22/2011
Decision Date:	12/11/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	10/06/2014

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:

According to the records made available for review, this is a 49-year-old female with a 5/22/11 date of injury, and arthroscopic labral debridement, arthroscopic subacromial decompression and arthroscopic Mumford procedure on 1/31/14. At the time (8/26/14) of request for authorization for One month home-based trial of a neurostimulator TENS-EMS unit, Physical Therapy for the left shoulder, left elbow, and cervical spine (2x4), and Extracorporeal Shock Wave Therapy (ESWT) for the left elbow medial/lateral epicondylitis, there is documentation of subjective (cervical spine, left shoulder, and left elbow pain) and objective (decreased range of motion of the cervical spine, tenderness to palpitation over the cervical paravertebral muscles, positive cervical compression test, decreased range of motion of the left shoulder, decreased range of motion of the left elbow, positive Cozen's test, and tenderness to palpitation over the acromioclavicular joint, anterior shoulder, infraspinatus, lateral shoulder, posterior shoulder, and supraspinatus) findings, current diagnoses (cervical disc protrusion, cervical myospasm, cervical pain, cervical radiculopathy, cervical sprain/strain, left shoulder internal derangement, left shoulder pain, left shoulder sprain/strain, left medial epicondylitis, left lateral epicondylitis, and left elbow sprain/strain), and treatment to date (12 physical therapy treatments, 24 post op physical therapy, and medications). Regarding One month home-based trial of a neurostimulator TENS-EMS unit, there is no documentation of a statement identifying that the TENS unit will be used as an adjunct to a program of evidence-based functional restoration, and a treatment plan including the long-term goals of treatment with the TENS. Regarding Physical Therapy for the left shoulder, left elbow, and cervical spine (2x4), there is no documentation of a statement of exceptional factors to justify going outside of guideline parameters and functional benefits or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of previous physical therapy treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

One month home-based trial of a neurostimulator TENS-EMS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous electrical nerve stimulation) Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) Page(s): 113-117.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, a statement identifying that the TENS unit will be used as an adjunct to a program of evidence-based functional restoration, and a treatment plan including the specific short- and long-term goals of treatment with the TENS, as criteria necessary to support the medical necessity of a month trial of a TENS unit. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of how often the unit was used, outcomes in terms of pain relief and function, and other ongoing pain treatment during the trial period (including medication use), as criteria necessary to support the medical necessity of continued TENS unit. Within the medical information available for review, there is documentation of diagnoses of cervical disc protrusion, cervical myospasm, cervical pain, cervical radiculopathy, cervical sprain/strain, left shoulder internal derangement, left shoulder pain, left shoulder sprain/strain, left medial epicondylitis, left lateral epicondylitis, and left elbow sprain/strain. In addition, there is documentation of pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed. However, there is no documentation of a statement identifying that the TENS unit will be used as an adjunct to a program of evidence-based functional restoration, and a treatment plan including the long-term goals of treatment with the TENS. Therefore, based on guidelines and a review of the evidence, the request for One month home-based trial of a neurostimulator TENS-EMS unit is not medically necessary.

Physical Therapy for the left shoulder, left elbow, and cervical spine (2x4): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Physical Therapy; Elbow, Physical Therapy; Neck & Upper Back, Physical Therapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow, Shoulder, and Neck & Upper Back, Physical Therapy (PT) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations,

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of Rotator cuff syndrome/ Impingement syndrome not to exceed 10 visits over 8 weeks, a diagnosis of Lateral epicondylitis/Medial epicondylitis not to exceed 8 visits over 5 weeks, and a diagnosis of Sprains and strains of neck not to exceed 10 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of cervical disc protrusion, cervical myospasm, cervical pain, cervical radiculopathy, cervical sprain/strain, left shoulder internal derangement, left shoulder pain, left shoulder sprain/strain, left medial epicondylitis, left lateral epicondylitis, and left elbow sprain/strain. In addition, there is documentation of 12 previous physical therapy treatments. However, given documentation of a request for Physical Therapy for the left shoulder, left elbow, and cervical spine (2x4), in addition to the treatments already completed, which would exceed guidelines, there is no documentation of a statement of exceptional factors to justify going outside of guideline parameters. In addition, there is no documentation of functional benefits or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of previous physical therapy treatments. Therefore, based on guidelines and a review of the evidence, the request for Additional post-operative physical therapy 2 times a week for 4 weeks is not medically necessary.

Extracorporeal Shock Wave Therapy (ESWT) for the left elbow medial/lateral epicondylitis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow, Extracorporeal shockwave therapy (ESWT)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 29.

Decision rationale: MTUS reference to ACOEM Guidelines state there is a recommendation against using extracorporeal shockwave therapy for evaluating and managing elbow complaints. Therefore, based on guidelines and a review of the evidence, the request for Extracorporeal Shock Wave Therapy (ESWT) for the left elbow medial/lateral epicondylitis is not medically necessary.