

Case Number:	CM14-0174716		
Date Assigned:	10/27/2014	Date of Injury:	08/08/2014
Decision Date:	12/17/2014	UR Denial Date:	10/08/2014
Priority:	Standard	Application Received:	10/21/2014

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 Internal 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 an injured worker with the diagnoses of cervical, lumbar, right shoulder, and right wrist strain and sprain. Date of injury is 08/08/2014. Mechanism of injury occurred while pushing a cart into an elevator, the malfunctioning elevator door continued to press on her from her right side of her body. An X-ray of the right hip performed 08/15/2014 revealed no significant findings. An X-ray of the lumbar spine performed 08/15/2014 revealed mild degenerative changes involving the lumbar intervertebral disk spaces with minimal narrowing. Mild osteoarthritic changes are seen involving both sacroiliac joints. An X-ray of the right toe performed 08/25/2014 revealed no significant abnormality. A MRI magnetic resonance imaging of the lumbar spine performed 09/23/2014 revealed mild disc degenerative disease of the lumbar spine at L2-3, L3-4, and L4-5. A MRI magnetic resonance imaging of the right hip performed 09/23/2014 revealed minimal right-side greater trochanter bursitis. A MRI magnetic resonance imaging of the right shoulder performed 09/29/2014, revealed mild degenerative changes of the acromioclavicular joint. A MRI magnetic resonance imaging of the cervical spine performed 09/29/2014 revealed no significant abnormality. The progress report dated 10/02/2014 documented the patient had completed 2 sessions of physical therapy (PT) by her previous primary treating physician. The patient complained of neck, right shoulder, low back and right wrist pain. The overall pain level remains at visual analogue scale 8/10. She continued to complain of neck pain that radiates to the right hand with numbness and tingling. Low back pain radiates to right calf with numbness and tingling in right foot. Objective findings were documented. Cervical examination demonstrated tenderness and decreased range of motion. Lumbar back had normal range of motion. Lumbar tenderness was noted. Right shoulder had decreased range of motion and tenderness. Right wrist had normal range of motion and tenderness. Right upper arm, forearm, and hand was non-tender. Right hip, knee, ankle, and foot

was non-tender with normal range of motion. Normal sensation and normal reflexes were noted. Straight leg raise test was normal. Gait was normal. Medical records indicate that the patient has completed 12 physical therapy sessions. The treatment plan included requests for transcutaneous electrical nerve stimulation (TENS) and additional physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS (Transcutaneous Electrical Nerve Stimulation) unit for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain (Chronic), TENS (Transcutaneous Electrical Nerve Stimulation)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 181; 203; 271; 308, Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) TENS (transcutaneous electrical nerve stimulation) Electrical stimulation

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) addresses transcutaneous electrotherapy. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints states that TENS is not recommended. ACOEM 2nd Edition (2004) Chapter 12 Low Back Complaints states that TENS is not recommended. ACOEM 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints states that TENS is not recommended for forearm, wrist, and hand Complaints. ACOEM 2nd Edition (2004) Chapter 9 Shoulder Complaints states that physical modalities, such as transcutaneous electrical neurostimulation (TENS) units, are not supported by high-quality medical studies. Official Disability Guidelines (ODG) state that electrical stimulation is not recommended for shoulder conditions. TENS is not recommended. The progress report dated 10/02/2014 documented that physical examination of the cervical spine demonstrated tenderness and decreased range of motion. Lumbar back had normal range of motion and lumbar tenderness. Right shoulder had tenderness and decreased range of motion. Right wrist had normal range of motion and tenderness. MRI magnetic resonance imaging of the lumbar spine performed 9/23/14 demonstrated mild disc degenerative disease of the lumbar spine at L2-3, L3-4, and L4-5. MRI magnetic resonance imaging of the right shoulder performed 9/29/14 demonstrated mild degenerative changes of the acromioclavicular joint. The MRI of the right shoulder was otherwise normal. MRI magnetic resonance imaging of the cervical spine performed 9/29/14 demonstrated no disc bulge, protrusion, or extrusion. MRI of the cervical spine demonstrated no abnormalities. MTUS and ACOEM guidelines do not support the medical necessity of transcutaneous electrical neurostimulation (TENS) for the patient's conditions. Therefore, the request for TENS (Transcutaneous Electrical Nerve Stimulation) unit for purchase is not medically necessary.

Physical therapy for the low back, neck, right shoulder and right wrist 2 times a week for 3 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC): Integrated Treatment/Disability Duration Guidelines, Forearm, Wrist and Hand (Acute and Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine Page(s): 98-99.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. The progress report dated 10/02/2014 documented that physical examination of the cervical spine demonstrated tenderness and decreased range of motion. Lumbar back had normal range of motion and lumbar tenderness. Right shoulder had tenderness and decreased range of motion. Right wrist had normal range of motion and tenderness. MRI magnetic resonance imaging of the lumbar spine performed 9/23/14 demonstrated mild disc degenerative disease of the lumbar spine at L2-3, L3-4, and L4-5. MRI magnetic resonance imaging of the right shoulder performed 9/29/14 demonstrated mild degenerative changes of the acromioclavicular joint. The MRI of the right shoulder was otherwise normal. MRI magnetic resonance imaging of the cervical spine performed 9/29/14 demonstrated no disc bulge, protrusion, or extrusion. MRI of the cervical spine demonstrated no abnormalities. The progress report dated 10/02/2014 documented the patient had completed 2 sessions of physical therapy (PT) with previous primary treating physician. Medical records indicate that the patient has completed 12 physical therapy sessions with the current primary treating physician. An additional 6 visits of physical therapy (PT) were requested. MTUS guidelines allow for up to 10 physical therapy visits. No exceptional factors were noted supporting the request to exceed MUTS recommendations. The request for 6 additional physical therapy visits is not supported. Therefore, the request for Physical therapy for the low back, neck, right shoulder and right wrist 2 times a week for 3 weeks is not medically necessary.