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| Case Number: | CM14-0179321 | | |
| Date Assigned: | 11/03/2014 | Date of Injury: | 06/27/2008 |
| Decision Date: | 12/12/2014 | UR Denial Date: | 09/26/2014 |
| Priority: | Standard | Application Received: | 10/28/2014 |

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 Family Medicine and is licensed to practice in New Jersey. 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 injured worker is a 54-year-old female who reported an injury on 06/27/2008. The mechanism of injury was not provided. Her diagnoses include right shoulder joint pain, lumbosacral spondylosis without myelopathy, and unspecified osteoarthritis. Her past treatments include a right shoulder cortisone injection that provided 60% relief for 3 months, an intramuscular Toradol injection on 04/17/2014 and a C7-T1 epidural steroid injection on 09/17/2013. The diagnostic studies include an MRI of the cervical spine on 04/14/2011, which revealed cervical fusion of C4 through C6, mild disc protrusion at C3-4, with moderate central spinal canal narrowing, and small disc protrusions seen at C2-3 and C6-7, which mildly indent the central spinal canal. Past surgical history includes cervical fusion on an unspecified date as well as unspecified shoulder surgery on an unspecified date. On 09/19/2014, the injured worker reported ongoing neck, right upper extremity, and diffuse low back pain that is increased with activity and partially relieved with medication. The objective findings revealed tenderness to palpation of an unspecified area, radiation of pain with deep palpation of an unspecified area, decreased muscle strength in the wrist extensors, the inability of the injured worker to perform a toe heel walk, and decreased range of motion in the lumbar spine. Additionally, she was noted to have soft tissue dysfunction and spasm in the cervical paraspinal, trapezius, and lumbar paraspinal regions, and intact deep tendon reflexes with decreased sensation of an unspecified area. Her current medications were noted to include Norco, Relafen, Topamax, lansoprazole, cyclobenzaprine, simvastatin, atenolol, and metformin. The treatment plan was noted to include continuation of opioids, NSAIDs, muscle relaxants, and stomach protective agents. A request was received for manual therapy plus infrared, a right shoulder cortisone injection with ultrasound guidance, and TENS application. A rationale was not provided. A Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Manual Therapy Plus Infrared: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

Decision rationale: The request for Manual Therapy Plus Infrared is not medically necessary. The California MTUS Guidelines recommend a trial of 6 visit of manual therapy over 2 weeks for the low back; and with documented evidence of objective functional improvement, a total of 18 visits over 6-8 weeks. The documentation submitted did indicate residual functional deficits; however, the injury occurred in 06/08/2008 and there was insufficient documentation to show conservative treatments received to date. Additionally, the request did not specify the targeted body region to receiving manual therapy. Therefore, in the absence of this documentation, the request is not supported by the evidence based guidelines. As such, the frequency for manual therapy plus infrared is not medically necessary.

Right Shoulder Cortisone Injection with Ultrasound Guidance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Steroid Injections

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Steroid injections

Decision rationale: The request for right shoulder cortisone injection with ultrasound guidance is not medically necessary. The California MTUS/ACOEM Guidelines recommend a subacromial cortisone injection after 2 to 3 weeks of conservative care. The documentation submitted indicated the injured worker had right shoulder pain. More specifically, the Official Disability Guidelines recommend a repeat injection with documented evidence of several weeks of temporary, partial relief of symptoms followed by worsening of pain and function. Additionally, the Official Disability Guidelines recommend ultrasound guidance of steroid injections as there is evidence that imaging improves accuracy. However, the guidelines do not recommend more than 3 steroid injections. The documentation submitted indicated the injured worker received a previous cortisone injection that provided 60% relief for approximately 3 months. However, there was insufficient documentation to show the total number of injections received since 06/2008. Additionally, there were no exceptional factors to significantly demonstrate the necessity of a cortisone injection at this time. Therefore, in the absence of this documentation, the request is not supported by the evidence based guidelines. As such, the

request for right shoulder cortisone injection with ultrasound guidance is not medically necessary.

TENS application: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS) Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-115.

Decision rationale: The request for TENS application is not medically necessary. The California MTUS Guidelines recommend a one month home based trial of transcutaneous electrical nerve stimulation (TENS) when used as an adjunct to evidence-based functional restoration program. However, the TENS is not recommended as a primary treatment modality. There was insufficient documentation to indicate an evidence based functional restoration program will be used in conjunction with TENS. Additionally, the request did not indicate the body part or region in which the TENS will be applied. Therefore, in the absence of this documentation, the request is not supported by the evidence based guidelines. As such, the request for TENS application is not medically necessary.