MAXIMUS Federal Services

Case Number:	CM14-0124335		
Date Assigned:	08/08/2014	Date of Injury:	03/20/2003
Decision Date:	07/13/2015	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/06/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Texas, Florida, California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 (IW) is a 62-year-old female who sustained an industrial injury on 03/20/2003 due to cumulative trauma. Diagnoses include cervical spine musculoligamentous sprain/strain, cervical spine radiculopathy, bilateral shoulder impingement syndrome, bilateral elbow medial and lateral epicondylitis, bilateral carpal tunnel syndrome, thoracic spine musculoligamentous sprain/strain, lumbar spine musculoligamentous sprain/strain, lumbar spine radiculopathy, chronic pain and disability with delayed functional recovery, status post (s/p) cervical spine surgery and s/p total knee replacements. Treatment to date has included medications, aqua therapy, physical therapy, acupuncture, lumbar and cervical epidural injections and trigger point injections, TENS unit, dietary management, bilateral knee surgery, cervical spine surgery and extracorporeal shockwave therapy. According to the Permanent and Stationary Evaluation Report dated 1/6/14 the IW reported intermittent bilateral shoulder pain rated 5/10 and frequently increasing to 8/10; intermittent bilateral hand/wrist pain rated 4/10 and frequently increasing to 5-6/10; and bilateral knee pain, worse on the right, rated 4/10 with associated clicking, popping and locking. On examination, there was tenderness to palpation, spasms and hypertonicity of the cervical, thoracic and lumbar paraspinals and the upper trapezius and levator scapulae. Spurling's test caused pain in the muscles of the neck radiating to the upper extremity. Exam of the shoulders was positive for tenderness over the biceps grooves and positive Neer's and Hawkins' tests. There was tenderness to palpation over the lateral and medial epicondyles of the elbows and positive Tinel's sign bilaterally of the elbows and wrists. Straight leg raise was positive bilaterally in the sitting position at 60 degrees on the right and 40 degrees

on the left. The left knee was mildly swollen, with tenderness to palpation over the medial joint line. Bilateral knee reflexes were 1. MRI of the lumbar spine 7/11/05 revealed grade I spondylolisthesis at L4-L5 with mild degenerative disc disease and spinal stenosis. MRI of the cervical spine 4/18/06 showed a paracentral disc bulge at C5-C6 and C6-C7 without significant spinal stenosis or foraminal narrowing. Electrodiagnostic studies were performed 1/17/13, showing mild right carpal tunnel syndrome. A retrospective request was made for one physical therapy session with electrical stimulator, infrared, ultrasound and massage for date of service 1/6/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for 1 Physical Therapy Session with Electrical Stimulator, Infrared, Ultrasound and Massage DOS: 1/6/2014: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 171, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic) Infrared therapy (IR).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98 of 127.

Decision rationale: This claimant was injured in 2003, now 12 years ago, reportedly from cumulative trauma. There are multiple strain injuries reported. The MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. And, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite: Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient. Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self-actualization. Moreover, these are primarily passive modalities; evidence based guides note that active care, in lieu of a purely passive program, is superior. This request for passive therapy modalities is not medically necessary.