

<b>Case Number:</b>	CM14-0177339		
<b>Date Assigned:</b>	10/30/2014	<b>Date of Injury:</b>	11/08/2004
<b>Decision Date:</b>	01/02/2015	<b>UR Denial Date:</b>	10/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2014

### 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 Emergency Medicine and is licensed to practice in New York. 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 sustained a work related injury November 8, 2004. Past medical history included diagnoses of hypothyroidism, depression and anxiety, ulcerative colitis, episodic jaw pain and clicking. Past surgical history included left foot bunion 2002, right shoulder surgery 2006, and bariatric surgery June 2014. At an initial TMJ consultation June 30, 2014, the injured worker visited with complaints of jaw muscle fatigue, lower jaw pain, and partial edentulous, pain with mastication, painless reciprocal click in the left and right TMJ and periodic facial pain. According to the evaluating physician, the injured worker stated the pain started in 2004, when assaulted at work resulting in post-traumatic stress disorder (PTSD), anxiety, bruxism, and present dental jaw problems. Joint finding on examination revealed; range of motion; maximum interincisal opening 47; muscle testing: superficial massiter pain on left, trapezius pain on the right and lateral pterygoid pain bilaterally. Panographic imaging reveals no acute process. The physician documents the diagnosis as bilateral MPD (myofascial pain dysfunction) and noncturnal bruxism. Treatment recommendations included referral to physical therapist, NSAIDs, and TMJ MRI. According to the treating physician's office visit dated July 31, 2014, the injured worker also has complaints of back and shoulder pain since the original injury in 2004. MRI of the lumbar spine dated July 20, 2012 revealed an L4-5 small disc bulge and posterior facet arthropathy with mild left greater than right foraminal narrowing, and no spinal stenosis or focal disc herniation. MRI of the right shoulder, revealed rotator cuff tendinosis/tendinopathy involving supraspinatus, AC joint arthrosis with a type III acromion and inferolateral tilt, possible mild long head of the biceps tenosynovitis, all of which appear chronic without definite acute disease. Treatments included continue Vicodin, Soma, Terocin patch, wrist splint and lumbar sacral support, and follow up with psychiatrist. On September 25, 2014, the injured worker presented to the treating physician

for chronic pain management of the left foot and ankle, right shoulder and arm, right hand and wrist, and discussion of treatment plan post TMJ consultation. Diagnostic impressions were documented as DeQuervain's right, carpal tunnel syndrome right, spondylolisthesis, lumbar radiculopathy, hallux rigidus, impingement syndrome right postoperative on the right and (PTSD) post-traumatic stress syndrome. The treatment plan included continue Vicodin and Soma, thumb spica standard splint and lumbosacral support, request for TMJ MRI and physical therapy three times per week for four weeks for bilateral nocturnal bruxism. Work status remains as temporarily totally disabled. According to the utilization review performed October 3, 2014, the injured worker was authorized with a temporomandibular joint(TMJ) orthotic splint, magnetic resonance imaging of the jaw, 12 sessions of physical therapy for the jaw 11/26/2012, and fitted with continuous positive airway pressure (CPAP) May 20, 2014. There were no exceptional factors noted in the documentation provided to consider a request outside of the MTUS and Official Disability Guidelines (ODG) guidelines for physical medicine. 12 physical therapy treatments for bilateral nocturnal bruxism were modified to 6 visits of physical therapy, for instruction and oversight of an independent home program of exercise and strengthening.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**12 physical therapy treatments for bilateral nocturnal bruxism:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medical Treatment Guidelines Pain Interventions and Guidelines Page(s): 98-99.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, TENS units, ultrasound, laser treatment, or biofeedback. They can provide short-term relief during the early phases of treatment. Active treatment is associated with better outcomes and can be managed as a home exercise program with supervision. Official Disability Guidelines (ODG) states that physical therapy is more effective in short-term follow up. 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). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted.

Recommended number of visits for myalgia and myositis is 9-10 visits over 8 weeks; and for neuralgia, neuritis, and radiculitis is 8-10 visits over 4 weeks. In this case, the requested number of treatments surpasses the six visits recommended for clinical trial. Therefore, this request is not medically necessary.