

<b>Case Number:</b>	CM14-0198048		
<b>Date Assigned:</b>	12/08/2014	<b>Date of Injury:</b>	10/07/2007
<b>Decision Date:</b>	01/23/2015	<b>UR Denial Date:</b>	10/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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 Physical Medicine Rehab, has a subspecialty in Interventional Spine Pain Management 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 a 57 year old male with an injury date on 10/07/2007. Based on the 04/28/2014 progress report provided by the treating physician, the diagnoses are: AC joint arthritis; Left Shoulder Rotator Cuff Tear and better ROM. According to this report, the patient complains of "left shoulder pain at night." Physical exam of the left shoulder shows "No atrophy" ROM: Flexion 130 degrees; Abduction 130 degrees; ER 80 degrees; IR to L3 also popping is noted with range of motion. The 09/03/201 report indicates the patient complains of "constant sharp pain along with numbness and tingling in his neck, left shoulder, right knee, and bilateral wrists. He rates his pain as a 7 on a scale of 1 to 10." Grip Strength Testing (R/L) by Jamar dynamometer: 42/35/40 pounds/35/50/48 pounds. The treatment plan is continue with HEP, refill medications, and follow up in 4 week. Patient's "TTD X4 weeks." There were no other significant findings noted on this report. The utilization review denied the request for Physical Therapy 2x3 on 10/02/2014 based on the MTUS guidelines. The requesting physician provided treatment report dates 04/28/2014 and an A.M.E report dates 09/03/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2x3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, Education Page(s): 474.

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

**Decision rationale:** According to the 04/28/2014 report, this patient presents with "left shoulder pain at night." The current request is for Physical Therapy 2x3 but the treating physician's report and request for authorization containing the request is not included in the file. The most recent progress report is dated 04/28/2014 and the utilization review letter in question is from 10/02/2014. For physical medicine, MTUS guidelines pages 98, 99 state that for myalgia and myositis, 9-10 visits are recommended over 8 weeks. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. The Utilization Review denial letter states " This claimant has had extensive PT/Chiro for this chronic condition." The number of sessions and the time-frame for this therapy are unknown. Review of the available records shows no therapy reports and there is no discussion regarding the patient's progress. If the patient did not have any recent therapy, a short course of therapy may be reasonable for declined function or a flare-up of symptoms. However, there is no documentation of flare-up or a new injury to warrant formalized therapy. The provider does not discuss the patient's treatment history or the reasons for requested additional therapy. No discussion is provided as to why the patient is not able to continue with the home exercises. MTUS page 8 requires that the provider provide monitoring of the patient's progress and make appropriate recommendations. The current request is not medically necessary.

**TENS Unit trial neck area:** Overturned

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

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

**Decision rationale:** According to the 04/28/2014 report, this patient presents with "left shoulder pain at night." The current request is for TENS Unit trial neck area but the treating physician's report and request for authorization containing the request is not included in the file. The most recent progress report is dated 04/28/2014 and the utilization review letter in question is from 10/02/2014. Regarding TENS units, the MTUS guidelines state "not recommended as a primary treatment modality, but a one-month home-based unit trial may be considered as a noninvasive conservative option" and may be appropriate for neuropathic pain. The guidelines further state a "rental would be preferred over purchase during this trial." Review of the medical records show the patient has neuropathic pain and has not had a one-month trial. The requested TENS Unit trial appears reasonable and is supported by the guidelines. The current request is medically necessary.