

<b>Case Number:</b>	CM15-0103134		
<b>Date Assigned:</b>	06/05/2015	<b>Date of Injury:</b>	10/21/2014
<b>Decision Date:</b>	07/09/2015	<b>UR Denial Date:</b>	05/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/28/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 46 year old male who reported an industrial injury on 10/21/2014. A second reported industrial injury is noted for 5/14/2015. His diagnoses, and/or impressions, are noted to include: cervical & thoracic spine musculoligamentous strain/strain with radiculitis; rule-out cervical and lumbosacral spine discogenic disease; right shoulder sprain/strain; and right index finger tenosynovitis. No current imaging studies are noted. His treatments have included medication management, therapy, and rest from work. The progress notes of 4/23/2015 reported headaches, left eye pain, neck pain, back pain, right shoulder pain, right index finger pain, loss of concentration, and sleeping problems. Objective findings were noted to include tenderness to the bilateral frontal head, cervical & thoracic spine, sub-occipital muscles, bilateral trapezius muscles, levator scapulae muscles, and right index finger; along with spasms, decreased range-of-motion and positive compression test; also decreased motor strength and sensation to the right upper extremity were reported. The physician's requests for treatments were noted to include the purchase of a trans-cutaneous electrical nerve stimulation unit; physical therapy for the cervical & lumbar spine, and right shoulder, hand and wrist; and x-rays of the cervical & lumbosacral spine, and right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transcutaneous electrical nerve stimulation (TENS) unit: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain, pages 114-117.

**Decision rationale:** Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of TENS Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. From the submitted reports, the patient has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive physical therapy, activity modifications, yet the patient has remained symptomatic and functionally impaired. There is no documentation on how or what TENS unit is requested, whether this is for rental or purchase, nor is there any documented short-term or long-term goals of treatment with the TENS unit. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the treatment already rendered. The Transcutaneous electrical nerve stimulation (TENS) unit is not medically necessary and appropriate.

**Physical therapy 2 times 6 for cervical spine, lumbar spine, right shoulder, right hand/wrist: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**Decision rationale:** Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support

further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy 2 times 6 for cervical spine, lumbar spine, right shoulder, and right hand/wrist is not medically necessary and appropriate.

**X-ray cervical spine, lumbosacral spine and right shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Chapter 8 Neck and Upper Back Disorders, Introductory Material, Special Studies and Diagnostic and Treatment Considerations, page(s) 171-171, 177-179.

**Decision rationale:** ACOEM Treatment Guidelines states Criteria for ordering imaging studies such as the requested X-rays of the lumbar spine include Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination and electro diagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist; however, review of submitted medical reports for this injury have not adequately demonstrated the indication for the x-rays nor document any specific clinical findings to support this imaging study and did not document any neurological exam or deficits. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The X-ray cervical spine, lumbosacral spine and right shoulder is not medically necessary and appropriate.