

<b>Case Number:</b>	CM15-0103682		
<b>Date Assigned:</b>	06/08/2015	<b>Date of Injury:</b>	09/01/2013
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	05/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 52-year-old female, who sustained an industrial injury on 9/1/13. She reported initial complaints of injury to the right shoulder, right wrist and low back. The injured worker was diagnosed as having displacement of thoracic or lumbar intervertebral disc without myelopathy; lumbago; rotator cuff tear right shoulder; right wrist triangular fibrocartilage tear; lumbar spine L5-S1 disc herniation. Treatment to date has included physical therapy; medications. Diagnostics included X-rays right shoulder 2 views (2/23/15); right hand X-rays (2/23/15; lumbar spine x-rays (2/23/15). Currently, the PR-2 notes dated 2/23/15 indicated the injured worker complains of right shoulder, right wrist and low back pain. Her chief complaint of low back pain remains primarily localized to the low back with radiation down both legs. She complains of numbness, tingling, and weakness of both legs. She denies any increased pain with Valsalva maneuver, as well as any bladder or bowel dysfunction. She complains of right shoulder pain exacerbated by overhead activities. She also complains of right wrist pain with clicking and catching. On physical examination of the right shoulder, notes marked pain elicited to palpation over the anterior aspect of the shoulder. The range of motion is slightly decreased with loss of 20 degrees of abduction and forward flexion. Supraspinatus and biceps motor strength is 4+/5. Arm circumferences are equal bilaterally; sensation is intact. Impingement tests II and I are positive. Examination of the right hand/ wrist reveals tenderness and clicking about the radioulnar joint, consistent with possible triangular fibrocartilage tear. The grip strength is 60/60/50 on the right and 50/50/40 on the left. Range of motion of the right upper extremity is full. Phalen's at 30 seconds, Tinel's on the median nerve and carpal tunnel compression test are

negative. Muscle strength and manual testing are normal. Range of motion of the fingers and thumb is normal. Examination of the thoracolumbar spine notes forward flexion to 60 degrees only; with fingertips failing to touch the toes by 30 cm. Arising is accomplished with difficulty and pain. Lateral bending is 40 degrees bilaterally without pain. Palpation of the lumbar spine reveals significant tenderness but no spasms. X-rays of the right shoulder (2 views) and humerus (2 views) shows spurring on the undersurface of the acromion. Right hand x-rays were normal. The lumbar spine x-ray shows degenerative disc disease at L5-S1 with loss of lumbar lordosis. The treatment plan is noting her lumbar spine is symptomatic and therefore, needs an updated lumbar MRI. The provider is also requesting physical therapy for right shoulder 12 sessions and a urine toxicology screen.

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

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

**Physical therapy 3 times a week for 4 weeks right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine guidelines Page(s): 474.

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

**Decision rationale:** The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine Guidelines Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. 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. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The goal of physical therapy is graduation to home therapy after a certain amount of recommended sessions. The request is in excess of these recommendations per the California MTUS. There is no reason why the patient would not be moved to home therapy after completing the recommended amount of supervised sessions. Therefore, the request is not medically necessary.

**Urine Toxicology screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids  
Page(s): 76-84.

**Decision rationale:** The California chronic pain medical treatment guidelines section on opioids states: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. The California MTUS does recommend urine drug screens as part of the criteria for ongoing use of opioids. The patient was not on opioids at the time of request and not showing aberrant behavior therefore the request is not medically necessary.

