

Case Number:	CM15-0107850		
Date Assigned:	06/12/2015	Date of Injury:	06/05/2014
Decision Date:	07/15/2015	UR Denial Date:	05/18/2015
Priority:	Standard	Application Received:	06/03/2015

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 was a 51 year old male, who sustained an industrial injury, on June 5, 2014. The injury was sustained from accumulative trauma and repetitive strain while working as a concrete finisher. The injured worker previously received the following treatments lumbar spine MRI, bilateral shoulder MRI, thoracic spine x-rays, bilateral shoulder x-rays, bilateral wrist x-rays, left knee x-rays, Lyrica, Pennsaid, Ultram, X-strength Tylenol, Ibuprofen, Carisoprodol, Biofreeze, hot/cold pack, lumbar pillow, physical therapy and left knee MRI. The injured worker was diagnosed with status post lumbar laminectomy at L3-L4 and L4-L5 levels, lumbar spine strain/sprain, diabetes mellitus, diabetic neuropathy, hypertension, high cholesterol, back pain, shoulder pain, left knee pain, bilateral foot pain, medial and lateral meniscus tears of the left knee, degenerative joint disease with osteoarthritis of the left knee. According to progress note of May 8, 2015, the injured workers chief complaint was mid back pain, bilateral shoulder, bilateral wrist and bilateral knee pain. The injured worker was reporting numbness and tingling sensation in both hands. The pain in the left knee occurs when standing, walking, kneeling and squatting. The bilateral shoulder pain, right greater than the left, was localized to the superior and posterior shoulders. The pain was aggravated by over the head work, far reaching, using a jackhammer and throwing heavy objects. The thoracic spine pain was manifested by the shoulder pain. The physical exam noted the injured worker ambulated without an assistive device. The bilateral shoulders had restricted range of motion with flexion and extension. There was tenderness with palpation of the right acromioclavicular joint, right coracoid process, right subacromial bursa, bilateral medial superior trapezii, bilateral medial scapulae, bilateral inframedial scapulae and bilateral mid-line thoracic upper back. The bilateral knees, there was tenderness with palpation over the left medial knee, medial joint line, pes anserine area and proximal medial tibia with positive McMurray's test. The treatment plan included physical therapy and TENS (transcutaneous electrical nerve stimulator) unit trail.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 12 weeks total 24: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 203, 299, 300, Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), back chapter, shoulder chapter, forearm, wrist and hand.

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

Decision rationale: This patient presents with mid back, bilateral shoulder, and bilateral knee pain. The current request is for Physical therapy 2 times a week for 12 weeks total 24. Treatment history included chiropractic visits, medications, hot/cold pack, lumbar pillow, physical therapy, and low back surgery (1991). The patient is not working. The MTUS Chronic Pain Management Guidelines, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." On 05/08/15, the patient continued to report neck, back and shoulder pain. The bilateral shoulder pain was localized to the superior and posterior shoulders, with restricted range of motion with flexion and extension. There was tenderness with palpation of the right acromioclavicular joint, right coracoid process, right subacromial bursa, bilateral medial superior trapezii, bilateral medial scapulae, bilateral inframedial scapulae and bilateral mid-line thoracic upper back. The thoracic spine pain was manifested by the shoulder pain. The treater recommended Physical therapy 2 times a week for 12 weeks "for home exercise program, shoulder scapular stabilization and spine stabilization." Supplemental report dated 05/01/15 provided a review of medical records which indicate that the patient participated in PT following the 1991 low back surgery and throughout 2007. There are no physical therapy reports provided for review. The exact number of completed physical therapy visits to date and the objective response to therapy were not documented in the medical reports. In this case, it appears as though this patient has not had any recent physical therapy. A short course to reinforce a home exercise program and to work on stabilization is reasonable; however, the current request is for 24 sessions which exceeds what is recommended by MTUS. This request IS NOT medically necessary.

TENS unit rental (unspecified duration): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back chapter, pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-116.

Decision rationale: This patient presents with mid back pain, bilateral shoulder, bilateral wrist and bilateral knee pain. The current request is for TENS unit rental (unspecified duration).

Treatment history included chiropractic visits, medications, hot/cold pack, lumbar pillow, physical therapy, and low back surgery (1991). The patient is not working. Per MTUS Guidelines page 116, TENS unit have not proven efficacy in treating chronic pain and is not recommend as a primary treatment modality, but a 1-month home-based trial may be considered for a specific diagnosis of neuropathy, CRPS, spasticity, a phantom limb pain, and multiple sclerosis. When a TENS unit is indicated, a 30-day home trial is recommended, and with the documentation of functional improvement, additional usage maybe indicated. On 05/08/15, the patient continued to report neck, back and shoulder pain. The bilateral shoulder pain was localized to the superior and posterior shoulders., with restricted range of motion with flexion and extension. There was tenderness with palpation of the right acromioclavicular joint, right coracoid process, right subacromial bursa, bilateral medial superior trapezii, bilateral medial scapulae, bilateral inframedial scapulae and bilateral mid-line thoracic upper back. The thoracic spine pain was manifested by the shoulder pain. The treater recommended Physical therapy and a "trials TENS unit." Supplemental report dated 05/01/15 provided a review of medical records which indicate that the patient already trialed a TENS unit in 2007. In this case, the patient has trialed a TENS unit with no documentation regarding frequency of use, magnitude of pain reduction, and functional changes with the use of a TENS unit. MTUS allows for extended use of the unit when there is documentation of functional improvement. This patient does not meet the criteria for extended use; therefore, this request IS NOT medically necessary.