

<b>Case Number:</b>	CM15-0167074		
<b>Date Assigned:</b>	09/04/2015	<b>Date of Injury:</b>	10/10/2014
<b>Decision Date:</b>	10/13/2015	<b>UR Denial Date:</b>	08/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2015

### 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: Pennsylvania

Certification(s)/Specialty: Internal Medicine, Hospice & Palliative Medicine

### 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 49 year old male, who sustained an industrial-work injury on 10-10-14. He reported initial complaints of back, shoulder and bilateral wrist pain. The injured worker was diagnosed as having thoracic, lumbosacral, bilateral shoulder, bilateral wrist sprain-strain, thoracic myofascitis, sacroiliac joint sprain, lumbar disc protrusion, bilateral shoulder osteoarthritis, and tendinitis. Treatment to date has included medication, physical therapy sessions (8), diagnostics, and acupuncture. MRI results were reported on 2-22-15 of left shoulder that demonstrated acromioclavicular osteoarthritis, supraspinatus tendinosis, and infraspinatus tendinosis. Lumbar MRI (magnetic resonance imaging) on 2-21-15 reported spondylosis a L3-S1 and disc desiccation at L3-S1. EMG-NCV (electromyography and nerve conduction velocity test) was reported on 4-10-15 and was negative. X-rays were reported on 1-20-15 of the right shoulder that demonstrated arthrosis of the acromioclavicular joint down sloping of the acromion which may predispose to impingement. The left shoulder had down sloping of the acromion which may predispose to impingement. X-ray of left-right wrist was essentially inconclusive. Currently, the injured worker complains of continued mid back pain, lower back pain, bilateral shoulder pain, and bilateral wrist pain. Per the primary physician's progress report (PR-2) on 7-10-15, exam noted decreased thoracic range of motion and painful, 2+ tenderness to palpation of the thoracic paravertebral muscles, muscle spasm of the paravertebral muscles. Lumbar range of motion is decreased and painful, positive Kemp's and straight leg raise bilaterally. Left shoulder range of motion is decreased and painful with 2+ tenderness of the lateral shoulder and trapezius and muscle spasm and supraspinatus press causes pain. The left-right wrist range of motion is

decreased. The requested treatment included 12 additional aquatic therapy and Purchase of interferential 4000 unit.

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

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

#### **12 additional aquatic therapy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** The MTUS Guidelines support the use of aquatic therapy as an optional form of exercise therapy that is an alternative to land-based treatments. This type of treatment minimizes the effects of gravity and is specifically recommended when reduced weight bearing is desirable, such as with extreme obesity. Active treatments can restore strength, function, and joint motion and can improve pain severity. The number of sessions should allow for the fading of treatment frequency. Workers are expected to continue self-directed treatments as an extension of therapy. The Guidelines recommend eight to ten visits over four weeks for treatment of neuralgia and/or radiculitis and nine to ten visits over eight weeks for treatment of myalgias. The submitted and reviewed documentation indicated the worker was experiencing mid- and lower back pain. The documented pain assessments were minimal and contained few of the elements encouraged by the Guidelines. There was no discussion describing a reason aqua therapy was expected to be more beneficial than a home exercise program. In the absence of such evidence, the current request for twelve additional sessions of aqua therapy is not medically necessary.

#### **Purchase of interferential 4000 unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** Interferential current stimulation is a type of electrical stimulation treatment for pain. The literature has not shown benefit from this treatment, possibly because of the limited quality studies available. The MTUS Guidelines support the use of this treatment only when it is paired with other treatments that are separately supported and in workers who have uncontrolled pain due to medications that no longer provide benefit, medications are causing intolerable side effects, a history of substance abuse limits the treatment options, the pain does not respond to conservative measures, and/or pain after surgery limits the worker's ability to participate in an active exercise program. A successful one-month trial is demonstrated by decreased pain intensity, improved function, and a decreased use of medication. The submitted and reviewed documentation indicated the worker was experiencing mid and

lower back pain. There was no suggestion of having failed treatment with medications, intolerable negative side effects, or any other related issues. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for the purchase of an interferential 4000 unit is not medically necessary.