

Case Number:	CM15-0192927		
Date Assigned:	10/07/2015	Date of Injury:	05/15/2015
Decision Date:	11/16/2015	UR Denial Date:	09/11/2015
Priority:	Standard	Application Received:	10/01/2015

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: 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 44-year-old female, with a reported date of injury of 05-15-2015. The diagnoses include right carpal tunnel syndrome, right impingement syndrome of the shoulder with subacromial bursitis, right elbow overuse, left carpal tunnel syndrome, left shoulder bursitis, left elbow overuse, cervical pain, cervical herniated nucleus pulposus with cord compression, anxiety and depression, and insomnia. Treatments and evaluation to date have included physical therapy, Tramadol, Naprosyn, Prilosec, and occupational therapy. The diagnostic studies to date have included an MRI of the cervical spine on 07-22-2015. The comprehensive orthopedic re-evaluation report dated 08-26-2015 indicates that the injured worker complained of neck pain with numbness of both hands in the middle of the night and at work; right shoulder pain; and right wrist tingling. It was noted that an MRI of the neck on 07-22-2015 showed reversal of the cervical curve, disc herniations at C4-5, C5-6, and C6-7, bulging at C3-4 and C7-T1, pressing of the cervical cord by the disc; an MRI of the right shoulder showed arthrosis of the acromioclavicular joint in the mediate and some tendonitis of the supraspinatus tendon; and electrodiagnostic studies showed evidence of carpal tunnel syndrome. It was noted that the injured worker was currently not working. It was also noted that the injured worker went to physical therapy two times a week, which helped her function better. An examination of the neck and shoulder showed cervical rigidity tenderness; decreased range of motion of about 25%; pain with range of motion; tenderness of the acromioclavicular joint; positive impingement test on internal rotation of her hand; tenderness over the biceps tendon; and decreased right shoulder range of motion. The treating physician indicates that the injured worker needed to continue physical therapy for her right shoulder, neck, and wrist. The

treatment plan included a prescription for an X-force with Solar Care to see if that will reduce some of the injured worker's symptoms temporarily. The injured worker was placed on temporarily totally disabled for six weeks. The request for authorization was dated 08-26-2015. The treating physician requested physical therapy two times a week for six weeks for the right shoulder, neck, and wrist; and an X-force stimulator with solar care for home use (indefinite use). On 09-11-2015, Utilization Review (UR) non-certified the request for an X-force stimulator with solar care for home use (indefinite use); and modified the request for physical therapy two times a week for six weeks for the right shoulder, neck, and wrist to four physical therapy sessions for the right shoulder, neck, and wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued physical therapy to right shoulder, neck and wrist Qty: 12: 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 Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

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 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 Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received previous therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments and remains not working. 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 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 Continued physical therapy to right shoulder, neck and wrist Qty: 12 is not medically necessary and appropriate.

X-force stimulator with solar care for home use, (indefinite use) Qty: 1: Upheld

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

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

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 a transcutaneous electrotherapy 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. There are no documented short-term or long-term goals of treatment with the X-Force Solar care unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the Unit without previous failed TENS trial. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the therapy treatment already rendered. MTUS guidelines recommend TENS as an option for acute post-operative pain and states TENS is most effective for mild to moderate thoracotomy pain; however, it has been shown to be of lesser effect or not at all effective for other orthopedic surgical procedures. Additionally, a form-fitting TENS device is only considered medically necessary with clear specific documentation for use of a large area that conventional system cannot accommodate or that the patient has specific medical conditions such as skin pathology that prevents use of traditional system, that demonstrated in this situation. The X-force stimulator with solar care for home use, (indefinite use) Qty: 1 is not medically necessary and appropriate.