

<b>Case Number:</b>	CM15-0199235		
<b>Date Assigned:</b>	10/14/2015	<b>Date of Injury:</b>	02/16/2015
<b>Decision Date:</b>	12/21/2015	<b>UR Denial Date:</b>	10/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2015

### 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: New York  
Certification(s)/Specialty: Internal 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 51 year old female, who sustained an industrial injury on 2-16-2015. Diagnoses include cervical spine disc bulge, thoracic spine strain, right shoulder strain, and right wrist-hand strain. Treatments to date include activity modification, medication therapy, and physical therapy. On 8-28-15, she complained of chronic pain secondary to pain in the low back, shoulder, and neck with radiation to bilateral shoulders and upper thoracic back. Current medications included Mobic, Flexeril, and compound creams topically. The physical examination noted crepitus in the neck with painful range of motion and muscle spasms. There was tenderness no cervical and lumbar spine. A positive facet loading maneuver was noted to cervical and lumbar spines. On 9-22-15, she complained of ongoing pain in the neck, upper back, right shoulder and right wrist and hand. The physical examination documented she presented with a right wrist brace in good condition. There were no abnormal findings documented. The appeal requested authorization for a right shoulder MRI, right wrist MRI, one PENS9P-Stim) four times for thirty days, twelve (12) physical therapy visits, and one initial visit with an orthopedist. The Utilization Review dated 10-1-15, denied this request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) MRI of the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic): Magnetic resonance imaging (MRI).

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

**Decision rationale:** MTUS recommends ordering imaging studies when there is evidence of a red flag on physical examination (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems), failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The injured worker complains of chronic bilateral shoulder pain. Chart documentation fails to show any red flags or unexplained physical findings on examination that to support the recommendation for MRI. The request for One (1) MRI of the right shoulder is not medically necessary by MTUS.

**One (1) MRI of the right wrist: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic): MRI's (magnetic resonance imaging).

**MAXIMUS guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hand Chapter.

**Decision rationale:** MTUS and ODG recommend Magnetic resonance imaging (MRI) in the evaluation of chronic wrist pain only when plain films are normal and other conditions such as soft tissue tumors are suspected. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The injured worker complains of chronic right wrist pain. At the time of the request under review, documentation failed to show objective clinical findings suspicious of other more serious conditions to support the recommendation for MRI. The request for One (1) MRI of the right wrist is not medically necessary per guidelines.

**One (1) PENS (P-Stim) four times/30 days: 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), Pain (Chronic): Auricular electroacupuncture.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter,

Percutaneous electrical nerve stimulation (PENS) and Other Medical Treatment Guidelines  
www.ncbi.nlm.nih.gov/pubmed/17187468.

**Decision rationale:** MTUS does not address this request. Percutaneous electrical nerve stimulation (PENS) is similar in concept to transcutaneous electrical nerve stimulation (TENS) but differs in that needles are inserted either around or immediately adjacent to the nerve serving the painful area and then stimulated. Per ODG, PENS is generally reserved for patients who fail to get pain relief from TENS, apparently due to obvious physical barriers to the conduction of the electrical stimulation (e.g., scar tissue, obesity). PENS is not recommended as a primary treatment modality, but a trial may be considered, if used as an adjunct to a program of evidence-based functional restoration, after other non-surgical treatments, including therapeutic exercise and TENS, have been tried and failed or are judged to be unsuitable or contraindicated. There is a lack of high quality evidence to prove long-term efficacy. PENS differs from P-Stim (P-Stimulation treatment), also known as Auricular acupuncture, which is a distinct form of acupuncture, where an electro-stimulation device is used to provide a continuous flow of intermittent, low frequency electrical pulses to specific peripheral nerves with end locations in the ear. Stimulation with the periodic signals can take place over four days, alternating three hours of stimulation with three hours of rest. The injured worker has chronic pain syndrome, with complains of chronic multiple joint pain. Documentation indicates prior trial of TENS unit and physical therapy with no significant objective improvement in level of pain or function. Established guidelines do not recommend the use of P-stimulation. Furthermore, there is lack of evidence of a specific functional restoration program being prescribed. The request for One (1) PENS (P-Stim) four times/30 days is not medically necessary.

**Twelve (12) physical therapy visits:** Upheld

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

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

**Decision rationale:** MTUS states that 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. As time goes, one should see an increase in the active regimen of care or decrease in the passive regimen of care and a fading of treatment of frequency. When the treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. The injured worker has chronic pain syndrome, with complains of chronic multiple joint pain. At the time additional outpatient physical therapy was prescribed, the injured worker had undergone an initial course of physical therapy with no significant objective improvement in pain or function. Given that this injured worker has completed a course of physical therapy and the lack of physician reports describing specific functional improvement, the medical necessity for further physical therapy has not been established. The request for Twelve (12) physical therapy visits is not medically necessary based on lack of functional improvement and MTUS.

**One (1) initial visit with an orthopedist:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Surgical Considerations.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management.

**Decision rationale:** MTUS, ACOEM, Chapter 5, Disability, Referrals, pg 92 MTUS states that a referral may be appropriate if the practitioner is uncomfortable with treating a particular cause of delayed recovery or has difficulty obtaining information or agreement to a treatment plan. Depending on the issue involved, it often is helpful to position a behavioral health evaluation as a return-to-work evaluation. The goal of such an evaluation is functional recovery and return to work. Documentation indicates that the injured worker has Chronic pain syndrome, with diagnosis of cervical spine disc bulge. Physician reports indicates the injured worker has failed conservative treatment, including activity modification, medication therapy, and physical therapy. The recommendation for Orthopedic Consult is reasonable. The request for One (1) initial visit with an orthopedist is medically necessary.