

Case Number:	CM15-0027079		
Date Assigned:	02/19/2015	Date of Injury:	06/05/2014
Decision Date:	04/07/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/12/2015

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 51 year old female, who sustained an industrial injury on June 5, 2014. She has reported pulling a heavy cart that fell over, developing immediate pain in the front of her right shoulder. The diagnoses have included labral tear and shoulder pain. Treatment to date has included physical therapy and medications. Currently, the injured worker complains of right shoulder pain, radiating down her arm with tingling and numbness down to her fingers. The Treating Physician's report dated August 6, 2014, noted the injured worker's right shoulder with anterior tenderness. A right shoulder x-ray was noted to show no evidence of fracture, dislocation, degenerative changes, loose bodies, or abnormal calcifications. A right shoulder MRI dated July 14, 2014, was noted to show a labral tear with an intact rotator cuff. On February 4, 2015, Utilization Review non-certified additional physical therapy evaluation/treatment, 2 x 4 to the shoulder, manual therapy techniques 2 times weekly for the shoulder, Iontophoresis 2 times weekly for the shoulder, and electrical stimulation 2 x weekly for the shoulder, noting there was no documentation of how many physical therapy visits the injured worker had completed that included manual therapy, iontophoresis or electrical stimulation, and no documentation of objective functional improvement as a result of the completed therapy. The MTUS Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines (ODG) were cited. On February 12, 2015, the injured worker submitted an application for IMR for review of additional physical therapy evaluation/treatment, 2 x 4 to the shoulder, manual therapy techniques 2 times weekly for the shoulder, Iontophoresis 2 times weekly for the shoulder, and electrical stimulation 2 x weekly for the shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy evaluation/treatment, 2 x 4 to the shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

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

Decision rationale: The patient presents with unrated right shoulder pain which is exacerbated by overhead reaching and elevation of the right upper extremity. The patient's date of injury is 05/05/14. Patient has no documented surgical history directed at this complaint. The request is for ADDITIONAL PHYSICAL THERAPY EVAL/TREATMENT, 2X4 TO THE SHOULDER. The RFA was not provided. Physical examination dated 08/06/14 reveals tenderness to palpation of the anterior aspect of the right shoulder, decreased range of motion on abduction, and decreased strength of the right upper extremity. The patient's current medication regimen was not provided. Diagnostic imaging included X-ray of the right shoulder dated 06/05/14, indicating normal findings. Patient's current work status is not provided. MTUS 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." In regards to the request for 8 physical therapy sessions for the management of this patient's chronic pain, the treater has not provided documentation of prior improvement to substantiate additional therapy. Progress note dated 08/06/14 states: "She has tried physical therapy with no improvement and actually increased pain." It is unclear how many sessions of physical therapy this patient has had to date as no other documentation of prior PT is included. While this patient presents with significant clinical history and continuing pathology of the lower extremity, without a specific number of physical therapy sessions completed to date and reports of improvement, additional sessions are not supported. The request IS NOT medically necessary.

Manual therapy techniques 2 times weekly for the shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 40, 59.

Decision rationale: The patient presents with unrated right shoulder pain which is exacerbated by overhead reaching and elevation of the right upper extremity. The patient's date of injury is 05/05/14. Patient has no documented surgical history directed at this complaint. The request is for MANUAL THERAPY TECHNIQUES 2 TIMES WEEKLY FOR THE SHOULDER. The

RFA was not provided. Physical examination dated 08/06/14 reveals tenderness to palpation of the anterior aspect of the right shoulder, decreased range of motion on abduction, and decreased strength of the right upper extremity. The patient's current medication regimen was not provided. Diagnostic imaging included X-ray of the right shoulder dated 06/05/14, indicating normal findings. Patient's current work status is not provided. MTUS Guidelines, page 40 states the following regarding Manual Therapy and Manipulation: "Recommended for chronic pain if caused by musculoskeletal conditions and manipulation is specifically recommended as an option for acute conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in function that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Treatment Parameters from state guidelines: a) Time to produce objective functional gains: 3-5 treatments. b) Frequency: 1-5 supervised treatments per week the first 2 weeks, decreasing to 1-3 times per week for the next 6 weeks, then 1-2 times per week for the next 4 weeks, if necessary. c) Optimum duration: Treatment beyond 3-6 visits should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session." Additionally, MTUS guidelines on page 59 states, "Delphi recommendations in effect incorporate two trials, with a total of up to 12 trial visits with a re-evaluation in the middle, before also continuing up to 12 more visits (for a total of up to 24)." In regards to the request for chiropractic treatment for this patient's chronic shoulder pain, the treater has not specified a number of sessions. MTUS guidelines indicate that manual manipulation such as chiropractic therapy be initiated on a trial basis with an optimum duration of 3-6 visits initially, with additional visits if there is documented objective improvement. While there is no evidence in the records provided that this patient has had any chiropractic treatment to date, this request does not imply intent to conduct a trial period or determine efficacy or provide a specific number of visits. Therefore, this request IS NOT medically necessary.

Iontophoresis 2 times weekly for the shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Shoulder Chapter, Iontophoresis.

Decision rationale: The patient presents with unrated right shoulder pain which is exacerbated by overhead reaching and elevation of the right upper extremity. The patient's date of injury is 05/05/14. Patient has no documented surgical history directed at this complaint. The request is for IONTOPHORESIS 2 TIMES WEEKLY FOR THE SHOULDER. The RFA was not provided. Physical examination dated 08/06/14 reveals tenderness to palpation of the anterior aspect of the right shoulder, decreased range of motion on abduction, and decreased strength of the right upper extremity. The patient's current medication regimen was not provided. Diagnostic imaging included X-ray of the right shoulder dated 06/05/14, indicating normal findings. Patient's current work status is not provided. ODG Shoulder Chapter, under Iontophoresis has the

following: "Not recommended. Iontophoresis has been tested for calcifying tendinitis of the shoulder and found to be ineffective, and there is no evidence showing effectiveness for other shoulder conditions. This randomized control trial of iontophoresis and ultrasound for the treatment of calcifying tendinitis of the shoulder found no significant difference between groups for any of the variables measured. Despite a trend toward greater improvement in the Shoulder Pain and Disability Index score in the treatment group, the use of iontophoresis and physical therapy for the treatment of calcifying tendinitis did not result in better clinical and radiologic effects than those observed in subjects treated by physical therapy alone."In regards to the request for iontophoresis for the management of this patient's persistent shoulder pain, guidelines do not support the requested therapy. Progress notes do not provide evidence that this patient has had previous iontophoresis, or provide documentation of efficacy. Nonetheless, ODG does not support this particular treatment owing to a lack of demonstrated clinical benefits. Therefore, the request IS NOT medically necessary.

Electrical stimulation 2 x weekly for the shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation Page(s): 121.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Shoulder Chapter, Electrical Stimulation.

Decision rationale: The patient presents with unrated right shoulder pain which is exacerbated by overhead reaching and elevation of the right upper extremity. The patient's date of injury is 05/05/14. Patient has no documented surgical history directed at this complaint. The request is for ELECTRICAL STIMULATION 2X WEEKLY FOR THE SHOULDER. The RFA was not provided. Physical examination dated 08/06/14 reveals tenderness to palpation of the anterior aspect of the right shoulder, decreased range of motion on abduction, and decreased strength of the right upper extremity. The patient's current medication regimen was not provided. Diagnostic imaging included X-ray of the right shoulder dated 06/05/14, indicating normal findings. Patient's current work status is not provided. ODG Shoulder Chapter, under Electrical Stimulation has the following: "Not recommended. For several physical therapy interventions and indications -eg, thermotherapy, therapeutic exercise, massage, electrical stimulation, mechanical traction, there was a lack of evidence regarding efficacy."In regards to the request for supervised electrical stimulation sessions for the management of this patient's persistent shoulder pain, guidelines do not support the requested therapy. Progress notes do not provide evidence that this patient has had previous electrical therapy, or provide documentation of efficacy. There is no documentation that this patient has had a successful trial of a TENS or ICS unit, either. Furthermore, ODG does not support this particular treatment owing to a lack of demonstrated clinical benefits. Therefore, the request IS NOT medically necessary.