

<b>Case Number:</b>	CM15-0055187		
<b>Date Assigned:</b>	03/30/2015	<b>Date of Injury:</b>	07/01/1992
<b>Decision Date:</b>	05/21/2015	<b>UR Denial Date:</b>	03/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/23/2015

### 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 60 year old female who sustained an industrial injury on 07/01/1992. Current diagnoses include cervical strain, herniated nucleus propulsus, right rotator cuff tear status post surgery, and left rotator cuff tear status post multiple upper extremity surgeries. Previous treatments included medication management, surgeries, and physical therapy. Previous diagnostic studies include urine drug screening, x-rays, and MRI. Report dated 03/04/2015 noted that the injured worker presented with complaints that included neck pain radiating down both arms. Pain level was not included. Physical examination was positive for abnormal findings. The treatment plan included prescribing medications for pain and spasms, request for physical therapy, and interferential (IF) unit in lieu of additional physical therapy. Disputed treatments include physical therapy sessions 2x4 (8) for the cervical spine and right shoulder and purchase of an IF unit for the cervical spine and right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PT sessions 2x4 (8 total) for the cervical spine and right shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**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 chronic 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 Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. 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 chronic 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 PT sessions 2x4 (8 total) for the cervical spine and right shoulder is not medically necessary and appropriate.

**Purchase of an IF unit for the cervical spine and right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential Current Stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, pages 115-118.

**Decision rationale:** The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage, increased pain relief or improved functional status derived from any transcutaneous electrotherapy to warrant a purchase of an interferential unit for home use for this chronic injury. Additionally, IF unit may be used in conjunction to a functional restoration process not demonstrated here. The Purchase of an IF unit for the cervical spine and right shoulder is not medically necessary and appropriate.