

<b>Case Number:</b>	CM15-0081667		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	10/17/2013
<b>Decision Date:</b>	06/22/2015	<b>UR Denial Date:</b>	04/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/28/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 32 year old man sustained an industrial injury on 10/17/2013 after a slip and fall. Evaluations include lumbar spine MRI dated 8/2014 and left shoulder MRI dated 8/1/2014. Diagnoses include left shoulder pain and chronic low back pain. Treatment has included oral medications and physical therapy. Physician notes dated 4/7/2015 show complaints of low back and left shoulder pain. Recommendations include additional physical therapy, foam roller, therma-care, and follow up in six weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy x 6 visits to left shoulder and low back:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant sustained a work-related injury in October 2013 and continues to be treated for shoulder and low back pain. When seen, he had completed 4 of 8 therapy sessions with some improvement. Pain was rated at 5/10. Tramadol was being prescribed. Authorization for additional physical therapy and a foam roller and an unspecified number of ThermaCare patches was requested. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the claimant had not completed the six-visit trial and requesting additional physical therapy was not medically necessary.

**DME: foam roller:** 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), Knee Chapter, DME.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant sustained a work-related injury in October 2013 and continues to be treated for shoulder and low back pain. When seen, he had completed 4 of 8 therapy sessions with some improvement. Pain was rated at 5/10. Tramadol was being prescribed. Authorization for additional physical therapy and a foam roller and an unspecified number of ThermaCare patches was requested. In terms of a home exercise program, patients are expected to continue active therapies at home. Compliance with a home exercise program would be expected and would not require specialized equipment. The requested foam roller is not medically necessary.

**DME: Thermacane:** 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), Knee Chapter, DME.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7: Chronic Pain, p168.

**Decision rationale:** The claimant sustained a work-related injury in October 2013 and continues to be treated for shoulder and low back pain. When seen, he had completed 4 of 8 therapy sessions with some improvement. Pain was rated at 5/10. Tramadol was being prescribed. Authorization for additional physical therapy and a foam roller and an unspecified number of ThermaCare patches was requested. In terms of thermal modalities, the use of heat and ice are low cost as at-home applications, have few side effects, and are noninvasive. The at-home

application of hot or cold packs is recommended. A simple, low-tech, reusable hot pack would meet the claimant's needs. Therefore, ThermaCare is not medically necessary.