

<b>Case Number:</b>	CM15-0083400		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	10/01/2002
<b>Decision Date:</b>	06/19/2015	<b>UR Denial Date:</b>	04/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2015

### 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: 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 58 year old female who sustained an industrial injury on 10/01/2002. The injured worker was diagnosed with cervical spine strain with radicular symptoms, right shoulder impingement syndrome, bilateral elbow lateral epicondylitis, bilateral carpal tunnel syndrome and right wrist ganglion cyst. Treatment to date includes conservative measures, diagnostic testing, surgery, physical therapy (6 sessions in the past year), acupuncture therapy (6 sessions in the past year), transcutaneous electrical nerve stimulation (TEN's) unit, home exercise program and medications. The injured worker is status post right shoulder arthroscopy, bilateral elbow revisions and bilateral carpal tunnel releases (no dates documented). According to the primary treating physician's progress report on March 11, 2015, the injured worker continues to experience neck pain. Examination of the cervical spine demonstrated tenderness to palpation about the paravertebral muscles with significant muscle spasm and restricted range of motion due to pain. The right shoulder was tender to palpation at the trapezius musculature with decreased range of motion. The left elbow had mild edema over the proximal forearm extensors. The bilateral wrists were tender with a cystic structure and pain greater on the right with a slight weakness in grip strength. Current medications are listed as Ibuprofen and Omeprazole. Treatment plan consists of medications and the current request for physical therapy to the cervical spine, cortisone injection to the right shoulder and transcutaneous electrical nerve stimulation (TEN's) unit supplies.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cortisone injection to the right shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Steroid injections.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) Corticosteroid injections, Steroid injections.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses shoulder complaints. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 9 Shoulder Complaints indicates that invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and nonsteroidal anti-inflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. Prolonged or frequent use of cortisone injections into the subacromial space or the shoulder joint is not recommended. Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) indicates that corticosteroid injections are indicated for the diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, and when pain interferes with functional activities. The pain management report dated 5/5/14 documented that the patient underwent right shoulder surgery in January 2008. The primary treating physician's progress report dated March 11, 2015 documented that examination of the right shoulder reveals tenderness to palpation about the trapezius musculature bilaterally. There is slightly restricted range of motion due to complaints of discomfort and pain. Diagnosis was bilateral shoulder strain, status post right shoulder arthroscopy. The physician requested authorization for the patient to undergo right shoulder cortisone injection. There was no evidence of adhesive capsulitis, impingement syndrome, or rotator cuff problems. Physical examination of the right shoulder demonstrated tenderness of the trapezius musculature, not the shoulder joint. The range of motion was described as only slightly restricted. The 3/11/15 physical examination does not support the medical necessity of a right shoulder cortisone injection. Therefore, the request for cortisone injection of the right shoulder is not medically necessary.

**TENS unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain, TENS, post operative pain. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back, TENS.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 173-174, 181-183, 203, 271, Chronic Pain Treatment Guidelines Transcutaneous

electrotherapy Page 114-121. Electrical stimulators (E-stim) Page 45. Decision based on Non-MTUS Citation ODG Neck and Upper Back (Acute & Chronic) Electrotherapies. Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) Electrical stimulation. ODG Elbow (Acute & Chronic) Electrical stimulation (E-STIM), Transcutaneous electrical neurostimulation (TENS). ODG Forearm, Wrist, & Hand (Acute & Chronic), Electrical stimulators (E-stim).

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses transcutaneous electrotherapy. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications. Neuromuscular electrical stimulation (NMES devices) is not recommended. Electroceutical Therapy (bioelectric nerve block) is not recommended. Galvanic Stimulation is not recommended. Microcurrent electrical stimulation (MENS devices) is not recommended. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints, Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints (Page 181-183) states that TENS is not recommended. ACOEM Chapter 8 (Page 173-174) states that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat / cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) state that electrotherapies are not recommended. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 9 Shoulder Complaints indicates that physical modalities, such as transcutaneous electrical neurostimulation (TENS) units, are not supported by high-quality medical studies. Official Disability Guidelines (ODG) state that electrical stimulation is not recommended for shoulder conditions. There is a lack of evidence regarding efficacy. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaint Table 11-7 Summary of Recommendations for Evaluating and Managing Forearm, Wrist, and Hand Complaints (Page 271) indicates that TENS units are not recommended. Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic) indicates that electrical stimulators (E-stim) are not recommended. Electrical stimulation units have no scientifically proven efficacy in the treatment of acute hand, wrist, or forearm symptoms. Official Disability Guidelines (ODG) Elbow (Acute & Chronic) indicates that electrical stimulation (E-STIM) is not recommended. Official Disability Guidelines (ODG) Elbow (Acute & Chronic) indicates that transcutaneous electrical neurostimulation (TENS) is not recommended. The primary treating physician's progress report dated March 11, 2015 documented subjective complaints of neck pain. Diagnoses were cervical spine strain with radicular complaints, bilateral shoulder strain, status post right shoulder arthroscopy, bilateral elbow lateral epicondylitis, status post surgery bilateral elbows, bilateral carpal tunnel syndrome, status post bilateral carpal tunnel release, and right wrist ganglion cyst. Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) indicate that electrotherapies are not recommended. ACOEM Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints (Page 181-183) states that TENS is not recommended. ACOEM and ODG guidelines do not support the use of TENS for shoulder conditions. ODG guidelines do not support the use of TENS for elbow

conditions. MTUS, ACOEM, and ODG guidelines do not support transcutaneous electrical nerve stimulation (TENS) for forearm, wrist, and hand conditions. Therefore, the request for TENS is not medically necessary.

**Physical therapy to the cervical spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back, Physical therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine Pages 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Physical medicine treatment. ODG Preface Physical Therapy Guidelines.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Official Disability Guidelines (ODG) present physical therapy PT guidelines. Patients should be formally assessed after a six visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. Per Medical Treatment Utilization Schedule (MTUS) definitions, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions, and a reduction in the dependency on continued medical treatment. The pain management report dated 5/5/14 documented that in approximately 2003 or 2004, the patient began to experience a gradual onset of pain in the hands and wrists. The patient was sent to an industrial clinic for evaluation. The patient underwent physical therapy modalities, however, she remained symptomatic. She was seen for an orthopedic evaluation. She gradually noted pain in her elbows and shoulders. MRI scans of the bilateral shoulders, elbows and wrists were obtained as well as EMG studies of the upper extremities. She was diagnosed with carpal tunnel syndrome and surgery was recommended. She subsequently underwent a right carpal tunnel release in 2005. She underwent a left carpal tunnel release approximately three months later. She followed up postoperatively after each surgery and underwent therapy rehabilitation. She underwent bilateral elbow surgery in 2006. She followed up postoperatively. She underwent right shoulder surgery in January 2008. She underwent postoperative therapy. Her shoulder pain gradually returned in 2012. On March 9, 2012, the patient was seen for an orthopedic evaluation. She underwent physical therapy modalities and acupuncture. She had only temporary relief. The primary treating physician's progress report dated March 11, 2015 documented subjective complaints of neck pain. Patient had a home exercise plan that did not benefit her greatly because she is still very symptomatic. Patient has had a total of 6 acupuncture sessions and 6 physiotherapy sessions within the past year. Patient has been using the TENs unit for 5 years. Patient has an impingement symptom in

her right shoulder with decreased strength in rotator cuff. Examination of the cervical spine reveals tenderness to palpation about the paraspinal muscles. There are significant muscle spasms noted. There is restricted range of motion due to complaints of discomfort and pain. Examination of the right shoulder reveals tenderness to palpation about the trapezius musculature bilaterally. There is slightly restricted range of motion due to complaints of discomfort and pain. Examination of the left elbow reveals mild edema over the proximal forearm extensors. Examination of the bilateral wrist and hand reveals a cystic structure at the wrist over and near the flexor carpi radialis tendon consistent with ganglion cyst with tenderness. There is restricted range of motion due to complaints of discomfort and pain, greater on the right. There is slight weakness in grip strength. Examination of the left elbow reveals mild edema over the proximal forearm extensors. Diagnoses were cervical spine strain with radicular complaints, bilateral shoulder strain, status post right shoulder arthroscopy, bilateral elbow lateral epicondylitis, status post surgery bilateral elbows with residuals, bilateral carpal tunnel syndrome, status post bilateral carpal tunnel release, and right wrist ganglion cyst. The physician requested authorization for the patient to undergo physical therapy at a rate of two times per week for four weeks. Physical therapy two times per week for four weeks for the cervical spine was requested. No functional improvement with past PT physical therapy was documented in the 3/11/15 progress report. Per ODG, patients should be formally assessed after a six visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. No functional improvement with past PT physical therapy was documented in the 3/11/15 progress report. The request for 8 visits of physical therapy exceeds MTUS guidelines, and is not supported. Therefore, the request for physical therapy is not medically necessary.