

<b>Case Number:</b>	CM15-0085856		
<b>Date Assigned:</b>	05/08/2015	<b>Date of Injury:</b>	02/05/2014
<b>Decision Date:</b>	06/29/2015	<b>UR Denial Date:</b>	04/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/04/2015

### 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, 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:

The injured worker is a 42-year-old male, who sustained an industrial injury on 2/5/14. He reported initial complaints of multiple body part pain. The injured worker was diagnosed as having contusion chest wall; sprain strain cervical; sprain/strain shoulder right. Treatment to date has included physical therapy (started 2/13/14); TENS unit; back brace; right wrist brace; medications. Diagnostics included x-rays cervical lumbar and right shoulder (2/5/14); MRI right shoulder (8/1/14); MRI cervical spine (8/1/14); MRI lumbar spine (8/1/14); EMG/NCV upper extremities (8/6/14). Currently, the PR-2 notes dated 2/5/14 indicated the injured worker complains of neck pain described as a burning sensation noted and an aching sensation along his right shoulder region and the right side of his lower back with numbness extending down the right arm. He has pins and needle sensation at the back of his right thigh and the outer aspect of his right leg. He takes Gabapentin and Tramadol for pain and has discontinued hydrocodone. He complains of neck, right shoulder and low back pain. His peripheral nervous system examination notes he complains of altered sensation extending down his right upper extremity and along his right lower into the out aspect of his right leg. He had a trigger point injection to the right shoulder of Marcaine and Kenalog and was provided with a dual muscle stimulator. He wears a back brace, right wrist brace and uses a cane occasionally. A physical examination was documented with cervical spine limited range of motions, right upper extremity altered sensation, and lumbar spine with limited range of motion, paraspinal spasm on palpation and positive radiculopathy of the lower extremities. X-rays impression of the lumbar spine showed degenerative joint disease with an irregular space at l3-4 and spondylolisthesis anteriorly Grade I; right shoulder calcified rotator cuff and cervical radiculopathy noted. The provider has requested Physical Therapy 2x4 neck, upper back, low back & r shoulder to include massage; Ultrasound; Electrical Stimulation to the cervical & lumbar spine & right shoulder & infrared treatment to the right shoulder and Referral pain management for cervical & lumbar spine. A

progress report dated April 28, 2015 states that the patient has been undergoing physical therapy 2 times a week for 3 weeks. The patient is noted to have sensory deficit corresponding to the C6, C7, and see a dermatomes on the right. Recommendation is made for an epidural injection and since the patient has "been unresponsive to conservative treatment (home exercise, PT, and NSAIDs)."

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Physical Therapy 2x4 neck, upper back, low back & r shoulder to include massage:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 ? 9792.26 MTUS (Effective July 18, 2009) Page(s): 98 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.

**Ultrasound:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

**Decision rationale:** Regarding the request for ultrasound, California MTUS does not address this issue. ODG states that it is not recommended based on the medical evidence, which shows that there is no proven efficacy in the treatment of acute low back symptoms. They go on to states that there is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing. As such, the currently requested ultrasound is not medically necessary.

**Electrical Stimulation to the cervical & lumbar spine & r shoulder & infrared treatment to the r shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 ? 9792.26 MTUS (Effective July 18, 2009) Page(s): 57 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Low Level Laser Therapy, Low Back Chapter, Cold/Heat Packs.

**Decision rationale:** Regarding the use of infrared, Chronic Pain Medical Treatment guidelines state that low level laser therapy such as red beam or near infrared therapy is not recommended. Guidelines indicate that there is insufficient evidence to support the use of this modality in the treatment of chronic pain. Regarding heat therapy, Occupational Medicine Practice Guidelines state that various modalities such as heating have insufficient testing to determine their effectiveness, but they may have some value in the short term if used in conjunction with the program of functional restoration. ODG states that heat/cold packs are recommended as an option for acute pain. Within the documentation available for review, and there is no indication that the patient has acute pain. Additionally, it is unclear what program of functional restoration the patient is currently participating in which would be used alongside the currently requested heat therapy. Additionally, no peer-reviewed scientific literature has been provided which would overrule the guidelines recommendations which do not support infrared treatment. As such, the currently requested infrared is not medically necessary.

**Referral pain management for cervical & lumbar spine:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines.

**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) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127 Other Medical Treatment Guideline or Medical Evidence: State of Colorado, Chronic Pain Disorder Medical Treatment Guidelines, Exhibit Page Number 52.

**Decision rationale:** Regarding the request for referral to pain management for consultation and treatment, California MTUS does not address this issue. ACOEM supports consultation if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Within the documentation available for review, the patient has ongoing pain corroborated by physical exam findings. Additionally, it appears the patient has failed numerous conservative treatments. As such, the currently requested referral to pain management for consultation and treatment is medically necessary.