

Case Number:	CM14-0097479		
Date Assigned:	07/25/2014	Date of Injury:	11/21/2013
Decision Date:	09/18/2014	UR Denial Date:	05/27/2014
Priority:	Standard	Application Received:	06/23/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 49-year-old female with date of injury of 11/21/2013. The listed diagnoses per [REDACTED] are: 1. Lumbar sprain/strain, pain. 2. Rule out lumbar disk protrusion. 3. Right rotator cuff tear and impingement syndrome. 4. Left shoulder impingement, rotator cuff tear, sprain/strain. 5. Right and left knee internal derangement, meniscus tear, pain. According to progress report 05/01/2014 by [REDACTED], the patient complains of lumbar spine, bilateral shoulder, and bilateral knee pain. Examination of the lumbar spine revealed MTP is present. The ranges of motion are decreased and painful. There is tenderness to palpation of the lumbar paravertebral muscles and muscle spasms noted. Kemp's test is positive bilaterally. Examination of the bilateral shoulder revealed tenderness to palpation of the acromioclavicular joint, anterior shoulder, lateral shoulder, and posterior shoulder. Supraspinatus test is positive bilaterally. Examination of the bilateral knee revealed decrease of range of motion with pain. There is tenderness to palpation of the anterior knee, lateral knee, and medial and posterior knee. McMurray's test is positive. Treater is requesting physical therapy 2 times a week for 4 weeks, chiropractic treatments 2 times a week for 4 weeks, LINT x6 sessions for the lumbar spine, ESWT of bilateral shoulders and knees, and a home TENS/EMS unit to help increase ROM and decrease pain. Utilization review denied the request on 05/27/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2x/week for 4 weeks: Upheld

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

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

Decision rationale: This patient presents with low back, bilateral shoulder, and bilateral knee pain. The treater is requesting additional physical therapy 2 times a week for 4 weeks to increase range of motion and activities of daily living and to decrease pain. Utilization review modified the certification from the requested 8 sessions to 6 sessions. For physical medicine, the MTUS Guidelines page 98 and 99 recommends for myalgia and myositis type symptoms 9 to 10 sessions over 8 weeks. The treater has reported the patient has completed 6 physical therapies to date. It is unclear as to what outcomes these prior treatments produced. The treater's request for 8 additional sessions with the 6 already received exceeds what is recommended by MTUS. Based on the above, this request is not medically necessary.

Chiropractic Therapy 2x/week for 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58,59.

Decision rationale: This patient presents with low back, bilateral shoulder, and bilateral knee pain. The treater is requesting chiropractic treatments 2 times a week for 4 weeks to increase range of motion and ADLs and to decrease pain. Utilization review denied the request stating, "There is not sufficient documentation indicating the concurrent authorization of this treatment in addition to physical therapy." (Insert guidelines for chiropractic therapy). Review of the medical file does not indicate the patient has trialed physical therapy in the past. MTUS recommends an optional trial of 6 visits over 2 weeks with evidence of functional improvement, total of up to 18 visits over 6 to 8 weeks. In this case, an initial trial of 6 visits may be recommended, but the treater's request for initial 8 sessions exceeds what is recommended by MTUS. Therefore, this request is not medically necessary.

LINT x 6 sessions for Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: This patient presents with low back, bilateral shoulder, and bilateral knee pain. The treater is requesting localized intense neurostimulation therapy (LINT) 6 sessions for

the lumbar spine to increase range of motion and activities of daily living and to decrease pain. The MTUS, ACOEM, and ODG Guidelines do not have discussions on LINT (localized intense neurostim therapy); however, for neuromuscular electrical stimulation, the MTUS Guidelines page 121 has the following, "not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use for chronic pain. There is no intervention trial suggesting benefit from NMES for chronic pain." In this case, there is no indication that this patient has suffered a stroke. Furthermore, MTUS does not support the use of neuromuscular electrical stimulation for chronic pain. The requested LINT therapy is not medically necessary.

Home TENS unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy; TENS, chronic pain (transcutaneous electrical nerve stimulation; Criteria for the use of TENS Page(s): 114; 114-116; 116.

Decision rationale: This patient presents with low back, bilateral shoulder, and bilateral knee pain. The treater is requesting a TENS unit. Utilization review denied the request stating, "There was no report of functional benefit from electrostimulation under the supervision of a licensed physical therapist." Medical file provided for review does not discuss prior use of a TENS unit and the treater does provide recommended duration of use. Per MTUS Guidelines page 116, TENS unit have not proven efficacy in treating chronic pain and is not recommended as a primary treatment modality, but a 1 month home-based trial may be considered for specific diagnoses of neuropathy, CRPS, spasticity, phantom limb pain, and multiple scoliosis. In this case, the treater is requesting a TENS unit, but does not document a successful home one-month trial. Therefore, this request is not medically necessary.

ESWT of Bilateral Shoulders & Knees: Upheld

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 Official Disability Guidelines (ODG).

Decision rationale: This patient presents with low back, bilateral shoulder, and bilateral knee pain. The treater is requesting extracorporeal shockwave therapy for the bilateral shoulders and knees to increase functional capacity, increase range of motion, increase activities of daily living, and decrease pain. The treater does not indicate number of sessions requested. he MTUS Guidelines and ACOEM Guidelines do not discuss ESWTs; however, the ODG Guidelines under ESWT for shoulders states, "Recommended for calcifying tendinitis, but not for other disorders, for patients with calcifying tendinitis of the shoulder in homogenous deposits, quality evidence have found extracorporeal shockwave therapy equivalent or better than surgery and it may be given priority because of its non-invasiveness." In this case, there is no diagnostic imaging that report calcium deposits on tendon or calcific tendinitis. The requested ESWT is not medically necessary.