

Case Number:	CM14-0217029		
Date Assigned:	01/06/2015	Date of Injury:	05/09/2014
Decision Date:	02/28/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/29/2014

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. 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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 is a 34 year old male with a work related injury dated 05/09/2014. Mechanism of injury was not noted in received medical records or in Utilization Review report. According to a primary physician's progress report dated 11/10/2014, the injured worker presented with complaints of right sided shoulder and low back pain. Diagnoses included lumbar pain and shoulder internal derangement. Treatments have consisted of medications, heating pads, ice packs, braces, chiropractic therapy, and physical therapy. Diagnostic testing included lumbar MRI dated 07/03/2014 which revealed at L5-S1, moderate disc degeneration with dehydration and narrowing and mild to moderate ligamentum flavum and facet hypertrophy. Right shoulder MRI on 07/03/2014 showed the rotator cuff with heterogeneous signal intensity changes compatible with chronic tendinopathy and moderate intrasubstance partial tearing and delamination of the distal supraspinatus, infraspinatus and superior fibers of the subscapularis tendons, without full thickness, retracted rotator cuff tear evident. Work status is noted as full duty. On 12/03/2014, Utilization Review non-certified the request for 8 physical therapy sessions for the right shoulder, 8 physical therapy sessions for the lumbar spine, 1 functional capacity evaluation, and 1 Transcutaneous Electrical Nerve Stimulation (TENS) Unit for 3-9 months citing California Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines. The Utilization Review physician stated that regarding physical therapy for the right shoulder, the injured worker has exceeding the recommended number of visits with only a mild improvement in his condition since the onset of physical therapy in 07/2014 with no other functional changes and there is no evidence of extraordinary factors to support variance from the

recommended number of sessions. Regarding physical therapy for the lumbar spine, the injured worker has had eight sessions certified and there has been minimal change with these sessions. In addition, there is no evidence of exceptional factors. Regarding the Functional Capacity Evaluation, there is no evidence of a planned work hardening program, proximity to maximal medical improvement, failed return to work attempts, conflicting medical reporting on work fitness, or work ergonomic assessment. In regards to the TENS Unit, the guidelines support TENS for chronic intractable pain related to limited conditions after a one month trial. There is no evidence of these conditions or significant benefit from a previous trial and no evidence of a recent surgical procedure. Therefore, the Utilization Review decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy x 8 for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Physical therapy guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical therapy Page(s): 98-99.

Decision rationale: According to the MTUS guidelines, therapy is recommended in a fading frequency. They allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The following diagnoses have their associated recommendation for number of visits. Myalgia and myositis, unspecified 9-10 visits over 8 weeks, Neuralgia, neuritis, and radiculitis, unspecified 8-10 visits over 4 weeks. In this case, there was already a request for therapy in August 2014 was for 8 sessions of physical therapy for the shoulder. here was no indication that additional sessions can not be completed at home. The amount of sessions completed are unknown =. The request for 8 additional physical therapy sessions is not medically necessary.

physical therapy x 8 for the lumbar spine: 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), Low Back- Lumbar and Thoracic

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

Decision rationale: According to the MTUS guidelines, therapy is recommended in a fading frequency. They allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The following diagnoses have their associated recommendation for number of visits. Myalgia and myositis, unspecified 9-10 visits

over 8 weeks, Neuralgia, neuritis, and radiculitis, unspecified 8-10 visits over 4 weeks. In this case, there was already a request for therapy in May 2014 for at least 8 sessions of physical therapy. There was no indication that additional sessions can not be completed at home. The amount of sessions completed are unknown =. The request for 8 additional physical therapy sessions is not medically necessary.

functional capacity evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG), Fitness for duty.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175, Chronic Pain Treatment Guidelines Functional Capacity Page(s): 48.

Decision rationale: According to the guidelines, Functional improvement measures are recommended. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. It should include the following categories: Work Functions and/or Activities of Daily Living, Self Report of Disability (e.g., walking, driving, keyboard or lifting tolerance, Oswestry, pain scales, etc): Objective measures of the patient's functional performance in the clinic (e.g., able to lift 10 lbs floor to waist x 5 repetitions) are preferred, but this may include self-report of functional tolerance and can document the patient self-assessment of functional status through the use of questionnaires, pain scales, etc (Oswestry, DASH, VAS, etc.) Physical Impairments (e.g., joint ROM, muscle flexibility, strength, or endurance deficits): Include objective measures of clinical exam findings. ROM should be in documented in degrees. Approach to Self-Care and Education Reduced Reliance on Other Treatments, Modalities, or Medications: This includes the provider's assessment of the patient compliance with a home program and motivation. The provider should also indicate a progression of care with increased active interventions (vs. passive interventions) and reduction in frequency of treatment over course of care. (California, 2007) For chronic pain, also consider return to normal quality of life, e.g., go to work/volunteer each day; normal daily activities each day; have a social life outside of work; take an active part in family life. (Cowan, 2008) According to the guidelines, activities at work that increase symptoms need to be reviewed and modified. A functional capacity evaluation is indicated when information is required about a worker's functional abilities that is not available through other means. It is recommended that wherever possible should reflect a worker's capacity to perform the physical activities that may be involved in jobs that are potentially available to the worker. In this case there is no mention of returning to work or description of work duties that require specific evaluation. No documentation on work hardening is provided. As a result, a functional capacity evaluation for the dates in question is not medically necessary.

Transcutaneous Electrical Nerve Stimulation (TENS) unit for 3-9 months: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS
Page(s): 113-115.

Decision rationale: According to the MTUS guidelines, a TENS unit is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. It is recommended for the following diagnoses: CRPS, multiple sclerosis, spasticity due to spinal cord injury and neuropathic pain due to diabetes or herpes. In this case, the claimant did not have the above diagnoses. The length of use was exceeded a 1 month trial period. In addition, the claimant had a prior similar request in August 2014. The request for a TENS for 3-9 months is not well defined and therapeutic response in that time frame can not be determined beyond a monthly basis. The TENS unit is not medically necessary.