

<b>Case Number:</b>	CM15-0121713		
<b>Date Assigned:</b>	07/02/2015	<b>Date of Injury:</b>	05/27/2014
<b>Decision Date:</b>	07/31/2015	<b>UR Denial Date:</b>	06/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/23/2015

### 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

### 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 50-year-old male sustained an industrial injury to the neck, back and right shoulder on 5/27/14. Previous treatment included magnetic resonance imaging, physical therapy, acupuncture, epidural steroid injections and medications. Electromyography/nerve conduction velocity test of bilateral upper extremities (10/22/14) was normal. In a doctor's first report of occupational injury dated 4/1/15, the physician indicated that the injured worker had undergone approximately 14 initial physical therapy sessions for the low back, neck and right shoulder with improvement to low back pain and little change in his neck and right shoulder pain. The injured worker subsequently received an additional 10 sessions of physical therapy without significant improvement to neck and right shoulder complaints. The injured worker currently complained of neck and right shoulder pain. Physical exam was remarkable for cervical spine with tenderness to palpation over the paraspinal musculature, suboccipital region and trapezius with spasms, trigger points and decreased range of motion and right shoulder with tenderness to palpation, crepitus upon passive range of motion, positive impingement test, slightly positive cross arm test and decreased range of motion. Current diagnoses included cervical spine sprain/strain, right shoulder subacromial bursitis, tendinitis and impingement with associated periscapular myofascial strain and lumbar spine sprain/strain. The treatment plan included physical therapy twice a week for six weeks for the right shoulder, right shoulder diagnostic ultrasound, medications (Ultram and Zanaflex) and an orthopedic surgery consultation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy additional one time a week for six weeks, right shoulder, lower back quantity:6.00:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**Decision rationale:** Review indicates the patient has completed at least 24 formal PT visits without functional change. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy additional one time a week for six weeks, right shoulder, and lower back quantity: 6.00 is not medically necessary and appropriate.

**Durable medical equipment home interferential stimulator 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, pages 115-118, Interferential Current Stimulation (ICS).

**Decision rationale:** The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage, increased pain relief or improved functional status derived from any transcutaneous electrotherapy to warrant an interferential unit for home use for this chronic injury. Additionally,

IF unit may be used in conjunction to a functional restoration process with improved work status and exercises not demonstrated here. The Durable medical equipment home interferential stimulator unit is not medically necessary and appropriate.