MAXIMUS Federal Services

Case Number:	CM15-0128772		
Date Assigned:	07/15/2015	Date of Injury:	05/21/2013
Decision Date:	08/20/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	07/03/2015

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: Pennsylvania, Ohio, 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:

The injured worker is a 60 year old female, who sustained an industrial injury on May 21, 2013. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having degenerative disc disease at cervical five to six and cervical six to seven and left shoulder adhesive capsulitis with impingement syndrome status post arthroscopy of the left shoulder with biceps tenodesis, anterior capsular release, and manipulation under anesthesia. Treatment and diagnostic studies to date has included laboratory studies, status post arthroscopy of the left shoulder, medication regimen, x-ray of the left shoulder and left humerus, and physical therapy. In a progress note dated May 20, 2015 the treating physician reports complaints of pain to the left shoulder. Examination reveals moderate pain, stiffness, limited range of motion, and weakness to the left shoulder. The injured worker's pain level was rated a 4 on a scale of 1 to 10. The documentation noted that the injured worker's medication regimen included Tramadol. The documentation provided noted that the injured worker received at least 24 sessions of physical therapy. Progress note from 04/08/2015 noted that prior physical therapy assisted the injured worker with increasing her range of motion, but she continues to have difficulty with muscle reflex activity with activities of daily living. The treating physician requested additional physical therapy three times a week for four weeks to maintain muscle strength and for soft tissue mobility to the left shoulder. The treating physician requested urine toxicology to assess the efficacy of the injured worker's medication regimen. The treating physician also requested an interferential unit with

supplies for a 30 to 60 day rental and purchase for long term use if the treatment is effective to manage pain and reduce medication use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy 3 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines. Decision based on Non-MTUS Citation www.odg-lwc.com/odgtwc/shoulder.htm.

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

Decision rationale: MTUS encourages physical therapy with an emphasis on active forms of treatment and patient education. This guideline recommends transition from supervised therapy to active independent home rehabilitation. Given the timeline of this injury and past treatment, the patient would be anticipated to have previously transitioned to such an independent home rehabilitation program. The records do not provide a rationale at this time for additional supervised rather than independent rehabilitation. This request is not medically necessary.

Urine toxicology screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

Decision rationale: MTUS recommends drug testing as an option to screen for aberrant behavior. The records do not clearly explain the drugs to be screened or the rationale as to why this testing has been requested. Therefore it is not possible to apply the guideline in support of this request. The request is not medically necessary.

If unit (inferential current stimulation) (retrospective 5/20/2015): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Stimulation Page(s): 118-120.

Decision rationale: MTUS recommends interferential stimulation as an option in specific clinical situations after first-line treatment has failed. Examples of situations where MTUS supports interferential stimulation include where pain is ineffectively controlled due to

diminished effectiveness of mediation or medication side effects or history of substance abuse. The records do not document such a rationale or alternate rationale as to why interferential stimulation would be indicated rather than first-line treatment. Therefore this request is not medically necessary.