

Case Number:	CM15-0062834		
Date Assigned:	04/09/2015	Date of Injury:	05/10/2011
Decision Date:	05/14/2015	UR Denial Date:	03/09/2015
Priority:	Standard	Application Received:	04/03/2015

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: California
Certification(s)/Specialty: Internal Medicine

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 33 year old female who sustained a work related injury May 10, 2011. According to a treating physician's pain management consultation and report, dated February 27, 2015, the injured worker presented with complaints of left anterior shoulder pain, right anterior shoulder pain, cervical and right elbow pain, rated 8/10. The discomfort at its worst is rated 9/10 and its best 3/10. There is palpable tenderness at cervical, right cervical and right cervical dorsal regions. There is also palpable tenderness of the right supraspinatus, anterior shoulder (bicipital tendon at origin), anterior deltoid, posterior deltoid, lateral deltoid and acromion process and clavicular joint. Diagnoses included cervical IVD (intervertebral disc disorder) disorder with myelopathy and rotator cuff syndrome-shoulder. Treatment plan included requests authorization for MRI of the cervical spine, left and right shoulder, physiotherapy, medications and home interferential stimulator unit, 60-day rental initial trial.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (magnetic resonance imaging) Cervical 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: Neck & Upper Back - Magnetic Resonance Imaging (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179, 181-183.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses cervical spine MRI magnetic resonance imaging. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints states that reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results). Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints (Page 181-183) states that radiography are the initial studies when red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection are present. MRI may be recommended to evaluate red-flag diagnoses. Imaging is not recommended in the absence of red flags. MRI may be recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. The orthopedic surgeon's report dated August 29, 2014 documented that the orthopedic surgeon referred the patient for a new MRI of the cervical spine. This procedure was performed. This showed evidence of mild degenerative changes but no frank evidence of disc herniation or nerve impingement. The orthopedic surgeon noted that the patient was back at work without restrictions. His physical examination findings showed normal range of motion in the cervical spine. Date of injury was 05-10-2011. The initial pain management consultation report dated 2/27/15 documented a new patient evaluation. No new neck injuries were reported. Past MRI studies were not referenced. MRI magnetic resonance imaging of the cervical spine was requested. No red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection were documented. The orthopedic surgeon's report dated August 29, 2014 documented that the orthopedic surgeon referred the patient for a new MRI of the cervical spine, which showed evidence of mild degenerative changes but no frank evidence of disc herniation or nerve impingement. The initial pain management consultation report dated 2/27/15 did not acknowledge or reference past MRI studies. The need for a repeat cervical spine MRI was not established. Therefore, the request for MRI of the cervical spine is not medically necessary.

Physiotherapy 2 times weekly for 3 weeks (6 sessions) - CS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine Pages 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Physical medicine treatment. ODG Preface, Physical Therapy Guidelines.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Official Disability Guidelines (ODG) present physical therapy PT guidelines. Patients should be formally assessed after a six visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. Per Medical Treatment Utilization Schedule (MTUS) definitions, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions, and a reduction in the dependency on continued medical treatment. The orthopedic surgeon's report dated August 29, 2014

documented that the orthopedic surgeon referred the patient for a new MRI of the cervical spine. This procedure was performed. This showed evidence of mild degenerative changes but no frank evidence of disc herniation or nerve impingement. The orthopedic surgeon noted that the patient was back at work without restrictions. His physical examination findings showed normal range of motion in the cervical spine. Date of injury was 05-10-2011. The orthopedic examination report dated 11/11/14 documented that the patient has had physiotherapy that has not helped. The initial pain management consultation report dated 2/27/15 documented a new patient evaluation. No new neck injuries were reported. Past physical therapy PT visits were not discussed. The number of past PT physical therapy visits was not documented. No functional improvement with past PT physical therapy visits. Per ODG, patients should be formally assessed after a six visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. Without documented functional improvement with past PT physical therapy visits, the request for physical therapy is not supported by MTUS or ODG guidelines. Therefore, the request for physical therapy is not medically necessary.

Interferential Stimulator Home Unit - Trial for 60 days - Bilateral Wrists: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271, Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page 114-121. Interferential Current Stimulation (ICS) Pages 118-120. Electrical stimulators (E-stim) Page 45. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Electrotherapies.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines addresses interferential current stimulation (ICS). Interferential current stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and methodologic issues. Although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints Table 11-7 Summary of Recommendations for Evaluating and Managing Forearm, Wrist, and Hand Complaints (Page 271) indicates that regarding physical treatment methods, TENS units and passive modalities are not recommended. Work Loss Data Institute guidelines for the forearm, wrist, & hand (acute & chronic) indicates that electrical stimulators (E-stim) are not recommended. Work Loss Data Institute guidelines for chronic pain (2013) indicates that interferential current stimulation (ICS) are not recommended. Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) state that electrotherapies are not

recommended. Work Loss Data Institute guidelines for the shoulder (acute & chronic) indicate that interferential current stimulation (ICS) is not recommended. The medical records document a history of neck, shoulder, and wrist complaints. MTUS, ODG, and Work Loss Data Institute guidelines do not support the use of interferential therapy. Therefore, the request for interferential unit for bilateral wrists is not medically necessary.