

Case Number:	CM15-0070472		
Date Assigned:	04/17/2015	Date of Injury:	08/03/2009
Decision Date:	05/18/2015	UR Denial Date:	03/12/2015
Priority:	Standard	Application Received:	04/13/2015

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:

The injured worker is a 33 year old male, who sustained an industrial/work injury on 8/3/09. He reported initial complaints of back, neck, shoulder pain with burns. The injured worker was diagnosed as having thoracic sprain/strain, cervical radiculopathy, lumbosacral radiculopathy, shoulder tendinitis/bursitis, elbow tendinitis/bursitis, and burns of multiple sites. Treatment to date has included medications, chiropractic care, acupuncture, steroid injections, psychological care, burn care, and skin grafting. Currently, the injured worker complains of intermittent pain and stiffness in the neck, traveling to the arms and hands, bilateral shoulder and arm numbness and tingling, frequent headaches. There was intermittent pain in the left knee. Per the orthopedic evaluation report (PR-2) on 2/12/15, examination noted spasm and tenderness over the paravertebral musculature, and upper trapezium. Deltoid motor power testing was 4/5. Sensory testing noted decreased with pain to the C5 and C6 dermatomes, bilaterally. Impingement and Hawkin's was positive bilaterally. Tenderness was noted to the lateral epicondyles and distal radius or carpus bilaterally. There was a slow gait with tenderness and spasm in the paravertebral muscle, sciatic notch area was tender bilaterally. The requested treatments include Prospective: Physical Therapy sessions to the cervical, lumbar spine, right shoulder only and prospective: 1 purchase of interferential unit for home use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective: 12 Physical Therapy sessions to the Cervical 7 Lumbar Spine, Right Shoulder Only: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 212.

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

Decision rationale: 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 Prospective: 12 Physical Therapy sessions to the Cervical 7 Lumbar Spine, Right Shoulder Only is not medically necessary and appropriate.

Prospective: 1 Purchase of Interferential Unit for Home Use: 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.

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 a purchase of an interferential unit for home use for this chronic injury. Additionally, IF unit may be used in conjunction to a functional restoration process with return to

work and exercises not demonstrated here. The Prospective: 1 Purchase of Interferential Unit for Home Use is not medically necessary and appropriate.