

<b>Case Number:</b>	CM14-0148856		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	05/13/2009
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	08/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/12/2014

### 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. The expert reviewer is Board Certified in Emergency Medicine and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 56-year-old female who reported an injury on May 13, 2009. The mechanism of injury was transferring a bed ridden patient. Diagnoses included partial thickness rotator cuff tear, arthritis, bursitis, and impingement of the left shoulder, and post release of the scar adhesions of the left shoulder. Past treatments included physical therapy. Diagnostic studies included an official x-ray of the left shoulder on September 8, 2014, which revealed acromioclavicular joint arthritis. Surgical history included three surgeries to repair the left shoulder rotator cuff tear. The clinical note dated September 8, 2014 indicated the injured worker complained of stiffness in the left shoulder, pain with overhead arm movement, and difficulty sleeping due to pain. Physical exam revealed decreased range of motion of the left shoulder with flexion of 110 degrees, extension 40 degrees, abduction 100 degrees and adduction 40 degrees. Muscle strength of the left shoulder was rated 4/5. Current medications were not provided. The treatment plan included additional physical therapy 3 times a week for four weeks, and a TENS (transcutaneous electrical nerve stimulation) unit. The rationale for the request was to increase strength, range of motion and flexibility. The Request for Authorization form was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional physical therapy, three times weekly for four weeks: Upheld**

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

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines indicate that physical therapy is beneficial for restoring flexibility, strength, endurance, function, range of motion and can alleviate discomfort. The guidelines indicate that physical therapy for patients with myalgia is recommended to include 9 to 10 visits over 8 weeks. The injured worker complained of pain and stiffness in the left shoulder. There is a lack of documentation of efficacy of the previous physical therapy to the left shoulder including quantified range of motion and strength values, functional improvement, and pain relief, as well as the number of sessions completed. Additionally, there is a lack of evidence of current conservative treatments including medications. The request also does not include the specific location to be addressed in physical therapy. Therefore, the request for additional physical therapy, three times weekly for four weeks, is not medically necessary or appropriate.

**A transcutaneous electrical nerve stimulation (TENS) unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Page(s): pages 114-116..

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines indicate that TENS is not recommended as a primary treatment modality, but a 1 month home based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence based functional restoration. The criteria for the use of TENS includes documentation of pain of at least 3 months duration, evidence that other appropriate pain modalities have been tried (including medications) and failed. Documentation during the trial period should include how often the unit was used, as well as outcomes in terms of pain relief and function. A treatment plan including the specific short and long term goals of treatment with the TENS should be submitted. The injured worker complained of pain and stiffness to the left shoulder. There is a lack of evidence of a previous 1 month TENS trial with documented functional improvement and pain relief, evidence that other appropriate pain modalities including medications had failed, or evidence of a treatment plan including the specific goals of treatment with the TENS unit. Additionally, the guidelines indicate that a 1 month trial should be completed prior to purchase of the unit. Therefore, the request for a TENS unit is not medically necessary or appropriate.