

Case Number:	CM13-0018156		
Date Assigned:	09/27/2013	Date of Injury:	02/06/2013
Decision Date:	01/15/2014	UR Denial Date:	08/09/2013
Priority:	Standard	Application Received:	08/29/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 physician 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.

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 patient is a 46-year-old female who reported an injury on 02/06/2013. She stated that her mechanism of injury was a slip and fall, which subsequently injured her ribs and lower back. An MRI of the lumbar spine was done on 07/01/2013, which showed mild disc bulges and mild central canal stenosis at L2-3 through L4-5. Heterogeneous increased T2 signal, between the L4 and L5 spinous processes suggesting a pseudarthrosis and a Baastrup's disease. According to the documentation dated 07/01/2013, the patient complained that her medication was only adequately decreasing her pain. The patient described her low back pain as a 9/10 with right extremity symptoms, and chest wall pain at 5/10. Her objective measurements included lumbar spine range of motion with flexion 50 degrees, extension 40 degrees, left and right lateral tilt 50 degrees, and left rotation 50 degrees. Her right lower extremity strength was documented as 4+/5 with diminished sensation at the right L4, L5, and S1 dermatomal distributions. SLR was noted as being positive on the right at 35 degrees. Her chest wall was noted as having no palpable gross bony abnormalities. The patient was noted as having spasms to the lumbar spine. At that time, the patient's diagnoses were listed as rule out right lumbar radiculopathy, low back pain, history of a right rib fracture, and reactive depression. The physician is currently requesting twelve (12) sessions of physical therapy for the lumbar spine, acupuncture w/modalities to the lumbar spine, QTY: 12.00, and one (1) purchase of an Interferential Unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

The request for physical therapy for the lumbar spine, QTY: 12.00: Upheld

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

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

Decision rationale: Regarding the first request for twelve (12) sessions of physical therapy for the lumbar spine, according to the California MTUS Guidelines, under Physical Medicine, active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Under the Guidelines, physical medicine allows for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active self-directed home physical medicine. A patient is allowed 9 to 10 visits over 8 weeks for myalgia and myositis unspecified, and is allowed 8 to 10 visits over 4 weeks for neuralgia, neuritis, and radiculitis unspecified. For those patients with reflex sympathetic dystrophy, they are allowed 24 visits over 16 weeks. As noted in the documentation, the patient has not been diagnosed as having reflex sympathetic dystrophy. Furthermore, there is not a comprehensive clinical evaluation provided for review. Therefore, objective measurements pertaining to the patient's range of motion and functional ability are unclear at this time. Because it is unclear if the patient is suffering from any functional deficits, or having problems with range of motion. Furthermore, the request for 12 sessions of physical therapy exceeds the Guidelines allowance for physical therapy sessions. As such, the requested service is not considered medically necessary at this time and is non-certified.

The request for acupuncture w/modalities to the lumbar spine, QTY: 12.00: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The Physician Reviewer's decision rationale: Regarding the second request for acupuncture w/modalities to the lumbar spine, QTY: 12.00, the California Acupuncture Guidelines have been referred to in this case. Under the Acupuncture Medical Treatment Guidelines, it states that acupuncture is used as an option when pain medication is reduced or not tolerated, and may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The Guidelines further state that frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) time to produce functional improvement is 3 to 6 treatments; (2) frequency is 1 to 3 times per week; (3) optimum duration is 1 to 2 months. The patient has been diagnosed as having low back pain with right lower extremity symptoms as well as chest wall pain; however, there is no comprehensive clinical documentation providing a detailed analysis of the patient's current pain scale or her range of motion and any kind of functional deficits she is suffering at this time. Furthermore, the request for acupuncture w/modalities to the lumbar spine, QTY: 12.00 exceed the Guideline allowance for acupuncture sessions. As such, the requested acupuncture w/modalities to the lumbar spine, QTY: 12.00 does not meet Guideline criteria and is non-certified.

One (1) purchase of an interferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-119.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-115.

Decision rationale: Regarding the last request for one (1) purchase of an Interferential Unit, according to the California MTUS Guidelines under the Transcutaneous Electrotherapy, a TENS unit is not recommended as a primary treatment modality, but a 1-month home based TENS trial may be considered as a non invasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The physician had requested physical therapy for this patient; however, the request for the number of sessions exceeded the maximum allowance per Guideline criteria. Furthermore, the request for the Interferential Unit did not indicate that the patient would be using this on a 1 month home based trial basis. Therefore, with both the adjunct therapy of physical medicine not meeting Guideline criteria, and with the total use of the Interferential Unit unclear, the requested service cannot be considered medically necessary at this time. As such, the requested one (1) purchase of an Interferential Unit is non-certified.