

<b>Case Number:</b>	CM13-0068247		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	07/31/2012
<b>Decision Date:</b>	06/02/2014	<b>UR Denial Date:</b>	11/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2013

### 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 Physical Medicine & 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 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 reported an injury on July 31, 2012. The mechanism of injury was the injured worker tripped over a rock. The diagnoses included cervical spine strain, bilateral carpal tunnel syndrome, bilateral lateral epicondylitis, bilateral knee internal derangement, and left ankle sprain. Prior treatments included physical therapy. The documentation from November 19, 2013 revealed that the injured worker had complaints of continuous pain in the neck and shoulders, elbow, and bilateral wrists/hands. The pain increased with gripping, grasping, flexing, extending, rotating, repetitive hand and finger motions. The injured worker complained additionally of low back pain, leg pain, bilateral knee pain, and right foot pain with radiation to right toes. The injured worker had difficulty sleeping and was unable to find a comfortable position secondary to pain. The injured worker had sensation reduced in bilateral median nerve distribution. The paravertebral muscles were tender with spasms. The range of motion was restricted. examination of the elbows revealed bilateral elbows that were tender to palpation. The injured worker had a positive Cousins/lateral epicondyle elbow/medial test that was positive bilaterally. Sensation was reduced in the bilateral median nerve distribution of the wrists. The Phalen's and Tinel's tests were positive bilaterally. The McMurray's test was positive bilaterally in the knees. The inferior medial aspect of both knees were tender to palpation. In the left ankle, the anterior taliofibular ligament was tender to palpation. The treatment plan included aqua therapy 3 times a week for 4 weeks to the neck and low back, hands, and knees, permanent use of a TENS unit for purchase, and a return followup visit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**AQUATIC PHYSICAL THERAPY SESSIONS 3 TIMES PER WEEK FOR 4 WEEKS IN TREATMENT OF THE CERVICAL SPINE, LUMBAR SPINE, BILATERAL HANDS, AND BILATERAL KNEES:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines AQUATIC THERAPY, PHYSICAL MEDICINE Page(s): 22,98-99.

**Decision rationale:** The California MTUS Guidelines recommend aquatic therapy as an optional form of exercise specifically recommended where reduced weight bearing is desirable. The guidelines indicate the treatment for myalgia and myositis is 9 to 10 visits. The clinical documentation submitted for review failed to indicate the injured worker had a necessity for reduced weight bearing. There is a lack of documentation of objective functional deficits to support the necessity for additional therapy. The request for aquatic therapy exceeds guideline recommendations. There is a lack of documentation of exceptional factors to warrant exceeding guideline recommendation. Given the above, the requested aquatic physical therapy is not medically necessary.

**PURCHASE OF TENS UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS) Page(s): 114-116.

**Decision rationale:** The California MTUS Guidelines recommend a one (1) month trial of a TENS unit as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least three (3) months of pain and evidence other appropriate pain modalities have been trialed and failed, including medications. The clinical documentation submitted for review failed to provide documentation of the above criteria. The request as submitted was for the purchase of a TENS unit. There was a lack of documentation indicating the injured worker had trialed a TENS unit and had objective functional benefit that was received from the unit as recommended by the California MTUS Guidelines. Given the above, the requested purchase of TENS unit is not medically necessary.

**PHYSIATRY FOLLOW UP IN FOUR WEEKS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, Page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Office Visits.

**Decision rationale:** The Official Disability Guidelines indicate the need for a clinical office visit with a healthcare provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The injured worker had reported the injury more than one (1) year prior to the request and had been treated with physical therapy. There was a lack of documentation indicating if the injured worker had a change in status to support the necessity for a repeat visits. There was a lack of documentation indicating the injured worker had objective functional deficits to support a necessity for further physiatrist treatment. The clinical documentation submitted for review failed to provide a necessity for a return visit. The injured worker's complaints were complaints of pain. Given the above, the requested physiatry follow-up is not medically necessary.