

<b>Case Number:</b>	CM14-0001301		
<b>Date Assigned:</b>	01/22/2014	<b>Date of Injury:</b>	03/23/2010
<b>Decision Date:</b>	06/16/2014	<b>UR Denial Date:</b>	12/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/03/2014

### 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 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 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 38-year-old female who reported an injury on 03/23/2010. The mechanism of injury was not provided for review. The injured worker reportedly sustained an injury to her neck. This ultimately resulted in anterior cervical decompression and fusion in 07/2013. The injured worker was treated postoperatively with physical therapy and medications. The injured worker was evaluated on 12/20/2013. Physical findings included restricted range of motion of the cervical spine described as 50 degrees in flexion, 50 degrees in extension, 65 degrees in right rotation and 50 degrees in left rotation with left lateral bending at 15 degrees and right lateral bending at 20 degrees. The injured worker's diagnoses included left shoulder sprain/strain, status post anterior cervical decompression and fusion, lumbar strain/sprain, bilateral wrist sprain/strain, bilateral epicondylitis, myoligamentous strain of the left knee, anxiety and depression, and insomnia. The injured worker's treatment plan included continuation of physical therapy, medications, and the use of a TENS unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY TWO TIMES A WEEK FOR SIX WEEKS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 24.

**Decision rationale:** The requested physical therapy 2 times a week for 6 weeks is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends up to 24 physical therapy visits for a status post fusion surgery. The clinical documentation does indicate that the injured worker has participated in postoperative physical therapy; however, the total number of visits that the injured worker has already participated in was not provided. Additionally, the clinical documentation does not provide evidence of clear significant benefits related to the previous therapy. Additionally, the request as it is submitted does not clearly indicate a body part. Therefore, the appropriateness of the request as it is submitted cannot be determined. As such, the requested physical therapy 2 times a week for 6 weeks is not medically necessary or appropriate.

**TENS UNIT FOR HOME USE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114 AND 116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS UNIT Page(s): 114.

**Decision rationale:** The requested TENS use for home use is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends the use of a TENS unit after a 30 day trial with documentation of significant functional improvement and pain relief. The clinical documentation submitted for review does not indicate that the injured worker has undergone a 30 day trial with documentation of functional benefit and pain relief. The request as it is submitted does not clearly define whether the TENS unit is for purchase or rental. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested TENS unit for home use is not medically necessary or appropriate.