

Case Number:	CM14-0002401		
Date Assigned:	01/24/2014	Date of Injury:	09/17/2000
Decision Date:	06/16/2014	UR Denial Date:	12/19/2013
Priority:	Standard	Application Received:	01/07/2014

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 Minnesota. 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 43-year-old male who reported an injury on 09/17/2000. The mechanism of injury was not stated. The current diagnosis is intracranial injury of other and unspecified nature without mention of an open intracranial wound. A physical therapy assessment summary was submitted on 07/15/2013. The injured worker demonstrated normal muscle tone, intact coordination, normal range of motion, independent sitting and standing balance, independent ambulation, independent bed mobility and transfers, limited activity tolerance due to discomfort, and a high sensitivity to temperature. The injured worker reported 5/10 pain with headaches. Treatment recommendations at that time included continuation of physical therapy and a TENS unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

SPEECH THERAPY 2X/WEEK X 12 WEEKS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Treatment for Workers Compensation Head Procedure Summary Last Updated 6/4/13.

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

Decision rationale: Official Disability Guidelines state a diagnosis of a speech, hearing, or language disorder resulting from an injury or trauma, or a medically based illness or disease is required prior to speech therapy. There should be evidence of a documented functional speech disorder resulting in an inability to perform at the previous functional level. The injured worker does not appear to meet criteria for the requested service. There is no documentation of a diagnosis of a speech, hearing, or language disorder. There is also no evidence of a speech disorder resulting in an inability to perform at the previous functional level. There is no documentation of an expectation by the prescribing physician of a measurable improvement that is anticipated within 4 months to 6 months. As the medical necessity has not been established, the request is non-medically necessary and appropriate.

PT 2X/WEEK X 12 WEEKS: Upheld

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

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

Decision rationale: California MTUS Guidelines state 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. Treatment for unspecified myalgia and myositis includes 9 to 10 visits over 8 weeks. The current request for 24 sessions of physical therapy exceeds guideline recommendations. There is also no specific body part listed in the current request. As such, the request is not medically necessary and appropriate.

TENS UNIT PURCHASE AND TENS UNIT SUPPLIES PURCHASE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home-based trial may be considered as a non-invasive conservative option. There should be evidence that other appropriate pain modalities have been tried and failed. As per the documentation submitted, there is no evidence of a successful 1 month trial prior to the request for a unit purchase. There is also no evidence of a treatment plan including the specific short and long term goals of treatment with the TENS unit. Based on the clinical information received and the California MTUS Guidelines, the request is not medically necessary and appropriate.