

Case Number:	CM14-0025211		
Date Assigned:	06/11/2014	Date of Injury:	06/27/2013
Decision Date:	07/28/2014	UR Denial Date:	02/05/2014
Priority:	Standard	Application Received:	02/27/2014

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 Illinois. 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 patient is a 45 year old female who was injured on 06/27/2013. She sustained an injury while she was pushing boxes from right to left onto a conveyor belt when she felt a pop in her back and had immediate pain. The patient has been treated conservatively with chiropractic therapy and 8 sessions of physical therapy. Diagnostic studies reviewed include an MRI of the lumbar spine dated 08/09/2013, which revealed a broad based posterior disc protrusion at L4-L5 with a superimposed 3 mm left paracentral/foraminal disc protrusion mildly impinging the left transiting L5 nerve that results in moderate left neural foraminal narrowing. A progress report dated 01/22/2014 indicates the patient complained of low back pain rated as 5/10. She reported the pain increases with repetitive bending and lifting. She is not taking medications. Objective findings on exam revealed no tenderness to palpation of the lumbar spine from L1 to the sacrum. Range of motion is 85%. Straight leg raise causes back pain. Sensation is intact. Motor strength is 5/5 in all planes. Deep tendon reflexes are 2/4. Diagnosis is L4-L5 and L5-S1, 2 mm disc protrusion with probable left radiculitis. Six additional sessions of physical therapy are requested. A prior utilization review dated 02/05/2014 states the request for additional physical therapy (pt) 2 x per week for 4 weeks (total of 8 visits) and tens unit rental x 30 days is not authorized as the patient has exceeded the quantity of physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL PHYSICAL THERAPY (PT) 2 X PER WEEK FOR 4 WEEKS (TOTAL OF 8 VISITS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12th Edition (web), 2014, Low Back- Physical therapy (PT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99 of 127.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical therapy to the spine guidelines.

Decision rationale: The MTUS Chronic Pain Guidelines recommends 10 visits over 4-weeks for lumbar strains and sprains, 8-10 visits over the course of 4-weeks for radiculitis, and 8-10 visits over the course of 4-week for myalgia and myositis not otherwise specified. The Official Disability Guidelines (ODG) regarding Physical Therapy (PT) for the spine recommends up to 10 visits over 8-weeks for intervertebral disc disorders and 10-12 visits for sciatica radiculitis over an 8-week period. The medical records document the patient has completed three separate courses of physical therapy, totaling twenty visits--six visits between 7/16/2013 and 7/25/2013; an additional six visits completed on 10/8/2013; and an additional eight visits between 1/3/2014 and 1/17/2014. The patient has exceeded the number of recommended visits for the diagnoses documented. As such, the request is not medically necessary.

TENS UNIT RENTAL X 30 DAYS: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-115.

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

Decision rationale: The MTUS Chronic Pain Guidelines indicate the use of TENS units for chronic intractable pain, including of the low back (defined as documented pain of at least 3-months duration) may be appropriate if a month-long trial demonstrates significant therapeutic effect. The medical records document the patient has not yet undergone a month-long trial of TENS. Therapy notes do document H-Wave electrical stimulation was tried and found to be helpful, however this is a separate and distinct device from TENS. Given that the injured worker has yet to attempt a month-long trial of TENS, the request is medically necessary and appropriate.