

<b>Case Number:</b>	CM14-0040655		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	12/01/2006
<b>Decision Date:</b>	08/18/2014	<b>UR Denial Date:</b>	03/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2014

### 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 Nevada. 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 67-year-old female who was reportedly injured on 12/1/2006. The mechanism of injury was not listed. The most recent progress note dated 1/30/2014, was handwritten and indicated that there were ongoing complaints of neck pain, shoulder pain and low back pains. Physical examination demonstrated tenderness and decreased range of motion of the cervical and lumbar spine, lumbar muscle spasming, decreased sensation in the right lower extremity, 5/5 motor strength, reflexes 2+ bilaterally, clonus absent and negative straight leg raise. No diagnostic imaging studies available for review. Diagnoses: Cervical degenerative disc disease with radiculopathy, right shoulder biceps rupture, chronic low back pain with right lower extremity radiculopathy and spondylolisthesis, anxiety, depression and gastritis. Previous treatment included a home exercise program, #24 physical therapy treatments and #2 chiropractic treatments. A request had been made for physical therapy x12 of the neck and lower back, acupuncture x12, transcutaneous electrical nerve stimulation (TENS) unit and supplies x3 months. A utilization review on 3/17/2014 partially certified physical therapy x2 visits and acupuncture x3 visits. TENS unit was not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy x 12, neck and lower back:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009 Page(s): 98-99.

**Decision rationale:** California Medical Treatment Utilization Schedule guidelines support the use of physical therapy for the management of chronic pain, specifically myalgia and radiculitis. It recommends a maximum of 8-10 visits over 4 weeks. He reported improvement with #24 physical therapy sessions. The current request for #12 additional physical therapy visits exceeds the amount supported by the chronic pain treatment guidelines. As such, this request is not considered medically necessary.

**Acupuncture x 12:**

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** California Medical Treatment Utilization Schedule guidelines support acupuncture as an option when pain medication is reduced or not tolerated and as an adjunct to physical rehabilitation to hasten functional recovery. The utilization review, dated 3/17/2014, partially certified #3 visits. When noting the claimant's diagnosis, date of injury, clinical presentation, a trial acupuncture is supported and treatments may be extended if functional improvement is documented as defined in Section 9792.20(f). Given the lack of documentation of response to 3 treatments, the request for #12 sessions is not considered medically necessary.

**TENS Unit and supplies x 3 months:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-1117.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 113-116.

**Decision rationale:** California Medical Treatment Utilization Schedule guidelines recommend against using a transcutaneous electrical nerve stimulation (TENS) unit as a primary treatment modality and indicates that a one-month trial must be documented prior to purchase of the unit. Review of the available medical records failed to document a one-month trial as well as outcomes in terms of pain relief and function or how often the unit was/is being used. As such, the request is not considered medically necessary.