

Case Number:	CM14-0062788		
Date Assigned:	07/11/2014	Date of Injury:	01/13/2006
Decision Date:	09/08/2014	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/05/2014

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 Family Practice and is licensed to practice in Ohio. 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 sustained an injury stemming from a fall on January 13, 2006. He has been diagnosed with lumbar and cervical radiculopathies, right shoulder pain, osteoarthritis of the right hip, anxiety and depression, hypertension, intolerance to nonsteroidal anti-inflammatory medication, and gastritis. Records from April 2013 from the pain medicine physicians reflect that the patient felt the TENS unit was helpful in relieving pain by 30% and allowing for an improvement in activities of daily living of teeth brushing, climbing stairs, dressing, driving, and walking. An epidural steroid injection was given in the lumbar region on August 8 of 2013 and resulted in no improvement in pain. On November 8, 2013 records from the pain medicine physicians reflect that the injured worker was complaining of pain in the neck radiating to the upper extremities and the low back radiating to the lower extremities and that his pain was a 2/10 with medication and a 9/10 without medication. The record also reflects that the pain was both improved and unchanged since the prior visit. Physical therapy was ordered at that visit. The initial physical therapy appointment was for December 10, 2013. The injured worker was felt to have mechanical right shoulder pain and he underwent cryotherapy, ultrasound, electrical stimulation, and myofascial release. He was found to have range of motion limitations in the right shoulder with positive impingement signs and numerous regions of trigger point tenderness of the right shoulder. The patient underwent six more sessions with physical therapy. A review of those records do not include a mention of range of motion improvement nor subjective improvements in pain. A note from the pain physicians from January 17, 2014 states that subjectively the patient's pain has worsened since last visit and again there is a statement regarding a 30% improvement in pain and improvement in activities of daily living with the TENS unit. There is no reconciliation between the statement of subjective pain worsening and pain improvement within the body of that note. Likewise, the medical record does not appear to

specify which portion of the body the TENS unit was utilized. There is a request in this note for four additional weeks of physical therapy to transition to a home exercise program. It is noted that the patient had continued muscle relaxants, cyclobenzaprine, for the nine-month period of record review.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 2 X A WEEK FOR FOUR WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Return To Work summary section, Physical Therapy topic.

Decision rationale: The injured worker had seven physical therapy sessions within the timeframe of review in which he underwent therapeutic exercises, cryotherapy, electrical stimulation, and myofascial release. The record fails to demonstrate meaningful progress that could be sustained until the next treatment session. Per the above guidelines, home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program. There should also be use of self-directed home therapy to facilitate fading of treatment frequency. Additionally, patients should be formally assessed after a six visit clinical trial prior to continue with physical therapy. Because the injured worker failed to make meaningful progress during the initial physical therapy, additional physical therapy to transition to a home exercise program is medically unnecessary.

CYCLOBENZAPRINE 10 MG, # 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES/MUSCLE RELAXANTS.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain section, Muscle relaxants topic.

Decision rationale: The injured worker had been maintained on a skeletal muscle relaxant, Flexeril, for eight months of the record review period. The above-mentioned guideline states that cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant which is recommended for a short course of therapy. However, there appears to be little evidence to allow for chronic use. It appears that the Flexeril is being used chronically in this instance. The use of cyclobenzaprine is not considered medically necessary per the above guidelines.

TENS UNIT SUPPLIES-INTERFERENTIAL UNIT SUPPLIES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
CHRONIC PAIN MEDICAL TREATMENT GUIDELINES/TRANSCUTANEOUS
ELECTROTHERAPY.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria
for the use of TENS Page(s): 116.

Decision rationale: Per the above guidelines, the criteria for the use of a TENS unit includes documentation of pain of at least three months duration, evidence that other pain modalities have been tried and failed, a one month trial period of the unit should be documented with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function, other ongoing treatment should be documented during the trial period, and a treatment plan including the specific short and long-term goals of treatment with the TENS unit should be submitted. In this case, a treatment plan detailing short and long-term goals is not included in the records reviewed. Therefore, the TENS unit supplies-inferential unit supplies are medically unnecessary.