

Case Number:	CM14-0076043		
Date Assigned:	07/21/2014	Date of Injury:	09/10/2013
Decision Date:	08/26/2014	UR Denial Date:	04/14/2014
Priority:	Standard	Application Received:	05/23/2014

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 Occupational Medicine 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:

According to the records made available for review, this is a 54-year-old male with a 9/10/13 date of injury. At the time (4/14/14) of the Decision for Physical Therapy X8 for Lumbar Spine and Pro Tech Multi- Stim Unit- Rental basis for Lumbar Spine, there is documentation of subjective (low back and radiating right leg pain) and objective (paravertebral muscle spasm, tenderness over the lumbar spine, positive SLR, and decreased sensation over the L4 and L5 dermatomes) findings, current diagnoses (lumbosacral sprain/strain, lumbosacral radiculitis, and lumbar disc syndrome), and treatment to date (medications and at least 7 previous physical therapy treatments). Medical reports identify limited improvement following completion of the 7th physical therapy session. Regarding physical therapy, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of previous physical therapy treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy X8 for Lumbar Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Physical therapy (PT).

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of lumbosacral radiculitis not to exceed 12 visits over 8 weeks. ODG also notes patients should be formally assessed after a six-visit clinical trial to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of lumbosacral sprain/strain, lumbosacral radiculitis, and lumbar disc syndrome. In addition, there is documentation of at least 7 previous physical therapy treatments, functional deficits, and functional goals. However, despite documentation of limited improvement following physical therapy, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of previous physical therapy treatments. In addition, the requested 8 treatments of physical therapy, in addition to the treatments already completed, would exceed physical therapy guidelines. Therefore, based on guidelines and a review of the evidence, the request for eight sessions off Lumbar Spine is not medically necessary.

Pro Tech Multi- Stim Unit- Rental basis for Lumbar Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) and Interferential Current Stimulation (ICS) Page(s): 113-120.

Decision rationale: MTUS reference to ACOEM identifies that physical modalities, such as transcutaneous electrical neurostimulation (tens) units, have no scientifically proven efficacy in treating acute low back symptoms. MTUS chronic pain medical treatment guidelines identifies that interferential current stimulation (ICS), microcurrent electrical stimulation (MENS devices), and neuromuscular electrical stimulation (NMES devices) are not recommended. Therefore, based on guidelines and a review of the evidence, the request for Pro Tech Multi- Stim Unit- Rental basis for Lumbar Spine is not medically necessary.

