

Case Number:	CM14-0205086		
Date Assigned:	12/17/2014	Date of Injury:	08/19/2013
Decision Date:	02/11/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/08/2014

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 Rehabilitation 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:

The patient is a 54 year old female with date of injury 08/19/13. The treating physician report dated 11/13/14 (13) indicates that the patient presents with pain affecting the low back. The patient notes cramping from lower back to down below the knee. The physical examination findings reveal the patient experiences pain in the right paraspinals more than the left, a pronounced pain extension of the lumbar spine, slightly positive SLR on the left and a limited range of motion on other planes. Prior treatment history includes chiropractic treatment, physical therapy, aquatic therapy, prescribed medications of Norco, Norflex, Naproxen, Ultracet, and a lumbar epidural steroid injection. MRI findings reveal multilevel degenerative changes with mild to moderate central stenosis at L4-5 and moderate to severe neuroforaminal narrowing right at L4-5 and left L5-S1. The current diagnoses are: 1. Sprain/Strain Lumbar Reg2. Displaced Lumbar Intervertebral Disc3. Spasm Of Muscle4. UNS Thoracic/Lumb Neuritis. The utilization review report dated 11/20/14 denied the request for TENS unit for home use, and Additional chiropractic therapy three times a week for four weeks based on a lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit for home use: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Electrotherapy/Transcutaneous Electrical Nerve Stimulation..

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

Decision rationale: The patient presents with pain affecting the low back. The current request is for a Tens Unit for home use. Length of usage is not stated in the documents provided. Per MTUS guidelines, TENS units have no proven efficacy in treating chronic pain and are not recommend as a primary treatment modality, but a one month home based trial may be considered for specific diagnosis of neuropathy, CRPS, spasticity, phantom limb pain, or Multiple Sclerosis. MTUS also quotes a recent meta-analysis of electrical nerve stimulation for chronic musculoskeletal pain, but concludes that the design of the study had questionable methodology and the results require further evaluation before application to specific clinical practice. While there is documentation that the patient has received electrical stimulation for a duration of ten minutes at the end of her physical therapy sessions, there is no evidence in the documents provided that shows the patient has previously been prescribed a TENS unit for a one month trial as indicated by MTUS. Furthermore, while a one month trial would be reasonable and within the MTUS guidelines, there is no indication of a designated time period the TENS unit would be used for home use. The current request does not satisfy MTUS guidelines as outlined on page 114. The request is not medically necessary.

Additional chiropractic therapy three times a week for four weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and treatments, Page(s): 58-59.

Decision rationale: The patient presents with pain affecting the low back. The current request is for Additional chiropractic therapy three times a week for four weeks. The treating physician report dated 11/13/14 notes that the patient states that chiropractic treatment is helping with her back. A UR report dated 09/30/14 shows that the patient received certification for chiropractic therapy 3x a week for 4 weeks. MTUS guidelines states the following regarding chiropractic treatment of the low back, "Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks." MTUS goes on to recommend "an initial trial of 6-12 visits over a 2-4 week period, and, at the midway point as well as at the end of the trial, there should be a formal assessment whether the treatment is continuing to produce satisfactory clinical gains. If the criteria to support continuing chiropractic care (substantive, measurable functional gains with remaining functional deficits) have been achieved, a follow-up course of treatment may be indicated consisting of another 4-12 visits over a 2-4 week period." In this case, there was a lack of documentation of measurable functional gains as required by the MTUS guidelines in order to recommend treatment beyond the initial trial of 6-12 visits. The request is not medically necessary.