

Case Number:	CM14-0206141		
Date Assigned:	12/18/2014	Date of Injury:	05/01/2013
Decision Date:	02/12/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	12/09/2014

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 37 year old male with date of injury 5/1/13, sustained while carrying a table. The requesting treating physician report was not found in the documents provided. The treating physician report dated 10/13/14 (24) indicates that the patient presents with pain affecting the neck, head, and low back with radiation into bilateral lower extremities accompanied with numbness and tingling in the right lower extremity. The patient describes the quality of pain as crushing and aching. The physical examination findings reveal tenderness of bilateral lumbar paraspinal muscles on palpation, a limited range of motion of lumbar spine accompanied with pain, and a positive straight leg raise test bilaterally. Prior treatment history includes physical therapy (18 sessions authorized on 12/18/13), massage therapy, and prescribed medications of Hydrocodone-Acetaminophen, Cyclobenzaprine, Ketoprofen and Tylenol extra strength. The current diagnoses are: 1. Myofascial pain syndrome 2. Back pain, lumbar 3. Lumbar radiculopathy. The utilization review report dated 11/13/14 (6) denied the request for Physical Therapy x12, and TENS unit 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:

Physical Therapy x12: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Physical medicine. Page(s): 98-99.

Decision rationale: The patient presents with pain affecting the neck, head, and low back with radiation into bilateral lower extremities accompanied with numbness and tingling in the right lower extremity. The current request is for Physical Therapy x12. The requesting treating physician report was not found in the documents provided. The UR report dated 11/13/14 (6) notes that a total of 18 sessions of physical therapy were authorized on 12/18/13. The UR report further notes that the patient reported exercising at least 3 times a week. The treating physician report dated 10/13/14 states that the patient was to continue with their home exercise program. MTUS supports physical medicine (physical therapy and occupational therapy) 8-10 sessions for myalgia and neuritis type conditions. The MTUS guidelines only provide a total of 8-10 sessions and the patient is expected to then continue on with a home exercise program. In this case, the patient has received 18 visits of physical therapy to date and the current request of 12 visits exceeds the recommendation of 8-10 visits as outlined by the MTUS guidelines on page 99. Furthermore, the patient has established a home exercise program. Recommendation is for denial.

TENS unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The patient presents with pain affecting the neck, head, and low back with radiation into bilateral lower extremities accompanied with numbness and tingling in the right lower extremity. The current request is for a TENS unit. 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. 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 therapeutic use. The current request does not satisfy MTUS guidelines as outlined on page 114. Recommendation is for denial.