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| <b>Case Number:</b>   | CM15-0103567 |                              |            |
| <b>Date Assigned:</b> | 06/08/2015   | <b>Date of Injury:</b>       | 09/18/2011 |
| <b>Decision Date:</b> | 08/27/2015   | <b>UR Denial Date:</b>       | 05/01/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/29/2015 |

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, California

Certification(s)/Specialty: Family Practice

### 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 47 year old female with an industrial injury dated 09/18/2011. Her diagnoses included lumbar 5-sacral 1 disc degeneration with left paracentral disc displacement and sacral 1 mild compression, bilateral knee chondromalacia patellofemoral, left knee pain secondary to antalgic gait, status post right knee arthroscopy with medial and lateral meniscectomy, lumbar 3-sacral 1 facet arthropathy and left sacral 1 radiculopathy. Prior treatments included chiropractic therapy and acupuncture therapy noting significant improvement in her symptoms. She is unable to utilize non-steroidal anti-inflammatory drugs secondary to gastric bypass surgery. Other treatments included physical therapy and lumbar epidural steroid injection at lumbar 5-sacral 1 which completely resolved left side lower extremity radicular pain. She presents on 04/06/2015 for follow up evaluation. She complains of a severe increase in low back pain that radiates up to the upper back pain, which began shortly after the epidural steroid injection. She rates the pain as 6/10 with medication and 10/10 without medication. Other areas of pain include bilateral hip pain, bilateral knee pain and bilateral foot pain. Physical exam noted a normal gait and normal heel-toe swing through gait with no evidence of limp. There was no tenderness to the paravertebral muscles of the spine on palpation. Treatment plan included physical therapy, diagnostic facet blocks, TENS unit and pain management follow up. The treatment request is for physical therapy lumbar spine 8 visits and TENS unit purchase. The patient had received an unspecified number of the PT visits for this injury. The patient has had EMG study of lower extremity that was within normal limits. The patient's surgical history include right knee arthroscopy on 12/13/11. The medication list

include Cymbalta, and Lyrica per the note dated 5/12/15 the patient had complaints of pain in low back with radiculopathy. Physical examination of the low back revealed tenderness on palpation, limited range of motion, normal gait and strength, decreased sensation in lower extremity and negative SLR. Patient had received ESI and facet joint injection for this injury. The patient has had MRI of the lumbar spine on 4/30/15 that revealed disc protrusions.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Physical therapy lumbar spine 8 visits:** 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 Physical therapy Page(s): 98.

**Decision rationale:** Request: Physical therapy lumbar spine 8 visits. The guidelines cited below state, "allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine." Patient has received an unspecified number of PT visits for this injury. Previous conservative therapy notes were not specified in the records provided. The requested additional visits in addition to the previously certified PT sessions are more than recommended by the cited criteria. The records submitted contain no accompanying current PT evaluation for this patient. There was no evidence of ongoing significant progressive functional improvement from the previous PT visits that is documented in the records provided. Previous PT visits notes were not specified in the records provided. There was no objective documented evidence of any significant functional deficits that could be benefitted with additional PT. Per the guidelines cited, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The medical necessity of the request for Physical therapy lumbar spine 8 visits is not fully established for this patient and is not medically necessary.

**TENS unit purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 115-117.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) page 114.

**Decision rationale:** TENS unit purchase. According the cited guidelines, electrical stimulation (TENS), is "not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While

TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness." Recommendations by types of pain: A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence for the use of TENS as noted below), and for CRPS I (with basically no literature to support use)." According the cited guidelines, Criteria for the use of TENS is "There is evidence that other appropriate pain modalities have been tried (including medication) and failed". A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted." Any evidence of neuropathic pain, CRPS I and CRPS II was not specified in the records provided. The patient had received an unspecified number of the PT visits for this injury. Detailed response to previous conservative therapy was not specified in the records provided. In addition a treatment plan including the specific short- and long-term goals of treatment with the TENS unit was not specified in the records provided. The records provided did not specify any recent physical therapy with active PT modalities or a plan to use TENS as an adjunct to a program of evidence-based functional restoration. It is noted that she is unable to utilize non-steroidal anti-inflammatory drugs secondary to gastric bypass surgery. However the response to other oral medications for pain, besides NSAIDS, (like tramadol) was not specified in the records provided. The medical necessity of the request for TENS unit purchase is not fully established for this patient.