

Case Number:	CM15-0188226		
Date Assigned:	09/30/2015	Date of Injury:	06/17/2015
Decision Date:	11/09/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/24/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 48 year old male, who sustained an industrial injury on 6-17-2015. The injured worker is undergoing treatment for: cervical spine sprain and strain, lumbar spine sprain and strain, bilateral shoulder sprain and strain, and bilateral wrist tendinitis. On 8-20-15, he reported pain to the neck, low back with radiation to the bilateral lower extremities, bilateral wrist and hands, bilateral shoulders with radiation to the right upper extremity, and headaches and dizziness. Physical examination revealed the neck with hypolordosis, tenderness and decreased range of motion, low back with tenderness, muscle guarding, and decreased range of motion, bilateral shoulder with tenderness, decreased range of motion, and negative impingement and cross arm tests, bilateral wrists with tenderness, decreased range of motion, negative tinel's, phalens and finkelsteins tests. The neurological examination revealed decreased sensation in the C5-C6 dermatomes and normal motor and reflexes were noted. The treatment and diagnostic testing to date has included: x-rays of the lumbar spine, cervical spine, and bilateral wrists (dates unclear), multiple completed physical therapy sessions, home exercises. The records dated 7-8- 15 indicated "the patient is responding well to physical therapy." Medications have included: ibuprofen. Current work status: modified duty. The request for authorization is for: physical therapy two times per week over 4 weeks for the cervical spine, lumbar spine, bilateral shoulder, and bilateral wrists; home interferential stimulation unit; electrodiagnostic studies of the bilateral upper extremities. The UR dated 9-2-2015: non-certified the requests for physical therapy two times per week over 4 weeks for the cervical spine, lumbar spine, bilateral shoulder, and bilateral wrists; home interferential stimulation unit; electrodiagnostic studies of the bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, twice a week for four weeks for cervical spine, lumbar spine, bilateral shoulders and bilateral wrists: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received previous therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical Therapy, twice a week for four weeks for cervical spine, lumbar spine, bilateral shoulders and bilateral wrists is not medically necessary and appropriate.

Home Interferential Stimulation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage, increased pain relief or improved functional status derived from any transcutaneous electrotherapy to warrant an interferential unit for home use for this chronic injury. Additionally, IF unit may be used in conjunction to a functional restoration process with improved work status and exercises not demonstrated here. The Home Interferential Stimulation is not medically necessary and appropriate.

Electrodiagnostic studies of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back, EMG and NCS.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: Per MTUS Guidelines, without specific symptoms or neurological compromise consistent with peripheral neuropathy or entrapment syndrome, radiculopathy, foraminal or spinal stenosis, medical necessity for EMG and NCV has not been established. Submitted reports have not demonstrated any symptoms or clinical findings to suggest any entrapment syndrome or cervical radiculopathy only with continued diffuse tenderness without neurological deficits or specific consistent myotomal or dermatomal correlation to support for the electrodiagnostics. There was no documented failed conservative trial for this injury without new injury or acute changed findings. The Electrodiagnostic studies of the bilateral upper extremities is not medically necessary and appropriate.