

Case Number:	CM15-0020220		
Date Assigned:	02/09/2015	Date of Injury:	08/01/2008
Decision Date:	04/03/2015	UR Denial Date:	01/19/2015
Priority:	Standard	Application Received:	02/03/2015

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, Arizona

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 55-year-old male who reported an injury on 08/01/2008 due to cumulative trauma. His diagnoses include lumbar radiculopathy, lumbar postlaminectomy L4-S1, and chronic pain syndrome. His past treatments include myofascial therapy, a home exercise program, massage therapy, and medications. On 01/12/2015, the injured worker complained of chronic neck, wrist pain with stiffness and numbness. The injured worker also complained of chronic lumbar spine pain radiating to the legs. The physical examination of the lumbar spine revealed loss of normal lordosis with straightening of the lumbar spine. There was also noted atrophy of the lumbar over the lower paraspinal muscles. The injured worker also had tenderness over the paravertebral muscles bilaterally and at the spinous process on the L3-5. The injured worker had a positive straight leg raise on the left and tenderness over the sacroiliac joint. The injured worker had a negative faber's test. The injured worker was indicated to have normal muscle strength throughout, except for the left knee flexor. Sensation and reflexes were also indicated to be normal and intact. His medications included Neurontin 100 mg; metformin 500 mg, lovastatin 40 mg, and lisinopril 2.5 mg. The treatment plan included myofascial therapy and a TENS unit. A rationale for the request was not provided. A Request for Authorization form was submitted on 01/12/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transcutaneous electrical nerve stimulation (TENS) unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

Decision rationale: The request for transcutaneous electrical nerve stimulation (TENS) unit is not medically necessary. According to the California MTUS Guidelines, TENS units are not recommended as a primary treatment modality; however, may be warranted for a 1 month trial to be used as an adjunct to a program of evidence based functional restoration. Furthermore, the guidelines indicate the criteria for TENS unit include: documentation of pain of at least 3 months in duration; evidence that other appropriate pain modalities have been tried and have failed; ongoing pain treatment should also be documented over the trial period, including medication usage; a treatment plan including the specific short and long term goals of treatment with the TENS unit should be submitted; and a rental would be preferred over a purchase during the trial phase. The injured worker was indicated to have chronic low back pain. However, there was lack of documentation in regard to other appropriate pain modalities that have been tried and failed to include medications. There was also lack of documentation to indicate the unit would be used in adjunct to a program of evidence based functional restoration. Furthermore, There was lack of a treatment plan, including the specific short and long term goals of treatment with the TENS unit. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Myofascial therapy sessions of the lumbar spine (1 times 6): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

Decision rationale: The request for Myofascial therapy sessions of the lumbar spine (1 times 6) is not medically necessary. According to the California MTUS Guidelines, massage therapy should be an adjunct to other recommended treatment, such as exercise, and should be limited to 4 to 6 visits. The injured worker was indicated to have completed 12 session of massage therapy. However, there was lack of documentation in regard to objective functional improvement; an objective decrease in pain; and evidence of a decrease in medication use from the previously completed visits. Furthermore, there was a lack of evidence in regard to a long term follow up indicating use of massage therapy. In addition, the guidelines do not recommend massage therapy for longer than 4 to 6 visits. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

