

Case Number:	CM15-0044261		
Date Assigned:	03/16/2015	Date of Injury:	04/11/2013
Decision Date:	04/22/2015	UR Denial Date:	02/06/2015
Priority:	Standard	Application Received:	03/09/2015

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 52 year old female, who sustained a work/ industrial injury on 4/11/13. She has reported initial symptoms of severe pain in the neck and back with radiation. The injured worker was diagnosed as having cervical sprain with radiation to the upper extremities, lumbar spine strain with radiation to the right lower extremity, rule out lumbar radiculopathy. Treatments to date included: medication, physical therapy, spine consult, and facet arthropathy with blocks. Magnetic Resonance Imaging (MRI) L3 vertebral hemangioma, mild intervertebral disc desiccation L5-S1, L1-2 focal central /left paracentral posterior disc protrusion, L2-3 focal central posterior disc protrusion, L5-S1 focal central posterior disc protrusion. Currently, the injured worker complains of persistent pain to the cervical, thoracic, and lumbar spine rated 7/10. The treating physician's report (PR-2) from 1/23/15 indicated, per examination, that the cervical spine had decreased range of motion with positive cervical compression. Examination of the thoracic spine revealed tenderness over the paraspinals. The lumbar spine revealed decreased range of motion with tenderness over the paraspinals, (R>L). There was positive straight leg raise (SLR) at 60 degrees to posterior thigh. There was decreased strength and sensation at 4/5 on the right at L4 and L5 only but normal at S1. There was normal strength and sensation at 5/5 on the left at L4, L5, and S1. Deep tendon reflexes were 2+ bilaterally at the patellar and Achilles tendons. Kemp's sign was positive bilaterally. Medications included Flexeril, Hydrocodone/APAP, Omeprazole, Nabumetone, and Tramadol. Treatment plan included physical therapy cervical and thoracic, large heating pad, and TENS unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Large heating pad. Qty:1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers' Compensation 2012 on the web (www.odgtreatment.com). Work Loss Data Institute (www.worklossdata.com), updated 2/14/12.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Initial approaches to treatments Page(s): 44.

Decision rationale: According to MTUS guidelines, "Musculoskeletal symptoms can be managed with a combination of heat or cold therapy, short-term pharmacotherapy (oral medication), a short period of inactivity, specific recommendations regarding employment and recreational activities, and judicious mobilization and resumption of activity, even before the patient is pain-free." There is no clear and recent documentation supporting the need for a heating pad to manage an acute pain. Therefore, the prescription of large heating pad is not medically necessary.

TEN's unit (days), Qty: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous Electrical Nerve Stimulation Page(s): 97.

Decision rationale: According to MTUS guidelines, TENS is not recommended as primary treatment modality, but a one month based trial may be considered, if used as an adjunct to a functional restoration program. There is no documentation of prior efficacy from electrical stimulation. There is no documentation that a functional restoration program will parallel the use of TENS unit. The provider should document how TENS will improve the functional status and the patient's pain condition. Therefore, the request of TENS Unit is not medically necessary.

Physical therapy cervical and thoracic. Qty: 1.00: 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 Medicine Page(s): 98.

Decision rationale: According to MTUS guidelines, Physical Medicine is “Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)” There is no documentation of the number, efficacy, and outcome of previous physical therapy sessions. There is no documentation that the patient cannot perform home exercise. Therefore, the request for Physical therapy cervical and thoracic is not medically necessary.