

Case Number:	CM15-0050379		
Date Assigned:	04/24/2015	Date of Injury:	06/28/2011
Decision Date:	06/11/2015	UR Denial Date:	03/10/2015
Priority:	Standard	Application Received:	03/17/2015

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 41 year old female, who sustained an industrial injury on June 28, 2011. She reported pain and tightness in the forearm, pain in the neck and back pain. The injured worker was diagnosed as having carpal tunnel syndrome and lesion of the radial nerve. Treatment to date has included diagnostic studies, muscle block and trigger point injections, physical therapy, medications and work restrictions. Currently, the injured worker complains of pain, and tightness in the neck, right forearm and back with associated right arm numbness and pain. The injured worker reported an industrial injury in 2011, resulting in the above noted pain. She was treated conservatively and surgically without complete resolution of the pain. Evaluation on March 31, 2015, revealed continued pain. Additional physical therapy and a permanent TENS unit were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Permanent TENS unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain, pages 114-117.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of TENS Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. From the submitted reports, the patient has chronic low back condition and has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive therapy, activity modifications, yet the patient has remained symptomatic and functionally impaired. There is no documentation on how or what TENS unit is requested, whether this is for rental or purchase, nor is there any documented short-term or long-term goals of treatment with the TENS unit. Although the patient has utilized the TENS unit prior, there is no evidence for change in work status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the TENS treatment already rendered. The Permanent TENS unit is not medically necessary and appropriate.

Physical therapy evaluation, neck and back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

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 chronic 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 Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant 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 chronic 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 evaluation, neck and back are not medically necessary and appropriate.

Physical therapy including physical performance test or measurement, neuromuscular reeducation, gait training and manual therapy techniques, 2 times a week for 2 weeks, neck and back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: Submitted reports have no acute flare-up or specific physical limitations to support for physical therapy. 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. There are unchanged chronic symptom complaints and clinical findings without clear neurological deficits. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. The patient is without clear specific functional improvement in ADLs, work status, or decrease in medication and utilization without physiologic evidence of tissue insult, neurological compromise, or red-flag findings to support further treatment. The Physical therapy including physical performance test or measurement, neuromuscular reeducation, gait training and manual therapy techniques, 2 times a week for 2 weeks, neck and back is not medically necessary and appropriate.