

Case Number:	CM14-0148886		
Date Assigned:	09/18/2014	Date of Injury:	06/16/2010
Decision Date:	12/24/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	09/12/2014

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 (IW) is a 37-year-old woman with a date of injury of November 21, 2011. The mechanism of injury was not documented in the medical record. Pursuant to the Primary Treating Physician's Progress Report (PR-2) and Request for Authorization dated July 14, 2014, the IW complains of pain in the neck and bilateral wrists, right greater than left. She also complains of soreness in her hands. She states that when she does activity, the pain returns and is rated 7/10. She is requesting medications and states that therapy helps. Objective physical examination reveals pain with resisted extension and bilateral rotation particularly to the right. There is tenderness about the paraspinal muscles with associated muscle guarding. There is muscle spasm formation over the right trapezius levator scapulae and right scapular muscles with palpable trigger noticed over the trapezius, levator scapulae, and the rhomboids. Focal palpation on the elbow elicits tenderness over the lateral epicondylar region and common extensor tendon with pain noted on Mill's and Cozen's testing. There is a positive Tinel's over the right carpal tunnel as well as a positive median compression. There is no atrophy or wasting on the median nerve innervating muscles of the hand. Current medications were not documented. The IW has been diagnosed with cervical spine sprain/strain; cervical spine myofascitis; DeQuervain's of the right; and right wrist sprain/strain. MRI of the cervical spine dated revealed a slight disc protrusion and reversal of the cervical curve. Upper extremity EMG/NCV was a normal study. The provider is recommending a short course of acupuncture care at 2 times a week for 3 weeks for the cervical spine and bilateral upper extremities, and a short course of physical therapy (PT). There is a PT Initial Evaluation note in the medical record dated April 30, 2014. It appears that the IW has been receiving PT, but it is unclear how many sessions she has completed. The Provider is also requesting a TENS unit for home use and is requesting an authorization for the IW to see a medical doctor for pharmaceutical management.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multi Stim Unit / TENS Unit plus supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Page(s): 116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Section, TENS Unit

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, the decision for multi-stimulation unit/TENS unit is not medically necessary. TENS is not recommended as a primary treatment modality, but a one month home-based tense trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration, including reductions in medications. The criteria for TENS use are enumerated in the ODG. These guidelines include, but are not limited to, evidence other appropriate pain modalities have been tried including pain medication and failed; a one month trial should be documented in addition to ongoing treatment modalities within a functional restoration approach; specific short and long-term goals of treatment with the tens unit should be submitted. In this case, the date of injury was November 21, 2011. The claimant's injuries are noted in the neck and bilateral wrists. An MRI showed a small disk protrusion in the cervical spine and an electrodiagnostic studies were negative. There were no medications prescribed and documented in the medical record. There was no documentation of a functional restoration approach to treatment. There were no specific short and long-term goals of treatment with the TENS unit in the documentation. Additionally, the guidelines allow a one month home-based trial as a conservative option. The treating physician's request does not specify the time duration. Consequently, the injured worker did not fulfill the criteria for TENS. Based on clinical information in the medical record and peer-reviewed evidence-based guidelines, decision for multi-stimulation unit/TENS unit plus supplies is not medically necessary.

Physical therapy 1 times 4-6 for the cervical spine and bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 98.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Section, Physical Therapy

Decision rationale: Pursuant to the Official Disability Guidelines, physical therapy one time per week times 4 to 6 weeks cervical spine and bilateral upper extremities is not medically necessary. Patients should be formally assessed after his sixth visit clinical trial to see if the

patient was moving in a positive direction, no direction or a negative direction (prior to continuing with the physical therapy). In this case, the documentation indicates the injured worker underwent a course of physical therapy. There is no clinical documentation as to objective functional improvement by the injured worker. The guidelines recommend objective documentation with the patient moving in a positive direction, no direction or negative direction prior to continuing with physical therapy. Consequently, in the absence of the appropriate supporting documentation, physical therapy one time per week for six weeks cervical spine and bilateral upper extremities is not medically necessary.