

<b>Case Number:</b>	CM14-0093377		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	01/30/2012
<b>Decision Date:</b>	10/09/2014	<b>UR Denial Date:</b>	05/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2014

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 is a 56-year-old female who reported an injury on 01/30/2012 due to a slip and fall. On 05/07/2014, the injured worker presented with low back pain radiating to the right lower extremity and right wrist pain. Upon examination of the right forearm, wrist, and hand, there was normal contour. There was no evidence of swelling or atrophy. There was tenderness to palpation present over the dorsal capsule and distal extensor of the forearm and wrist. There was tenderness over the first dorsal extensor compartment and a negative Tinel's over the carpal tunnel and negative Phalen's. Examination of the thoracolumbar revealed normal contour and no evidence of antalgia. There was a positive bilateral straight leg raise and range of motion values were 45 degrees of flexion, 10 degrees of extension, 12 degrees of right side bending, and 12 degrees of left side bending. There was decreased sensation over the L5-S1 nerve root distribution, and the injured worker ambulated with a slow, guarded gait. The diagnoses were thoracic musculoligamentous sprain/strain, lumbosacral musculoligamentous sprain/strain, and right wrist sprain. Prior therapy included medications. The provider recommended physical therapy 8 sessions 2 times 4 and a home electrical muscle stimulation unit Orthostim4, the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 8 session (2 x 4): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**Decision rationale:** The California MTUS states that 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 for the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There was lack of documentation of the injured worker's prior course of physical therapy, as well as efficacy of the prior therapy. Additionally, there are no significant barriers to transitioning the injured worker to an independent home exercise program. There was lack of documentation on the amount of physical therapy visits the injured worker previously underwent. The provider's request does not indicate the site at which the physical therapy sessions were indicated for in the request as submitted. As such, the request for Physical therapy 8 sessions (2 x 4) is not medically necessary.

**Home electrical muscle stimulation unit, Orthostim4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Page(s): 118-119.

**Decision rationale:** The request for Home electrical muscle stimulation unit, Orthostim4 is not medically necessary. The California MTUS Guidelines do not recommend electrical muscle stimulation as an isolated intervention. There is no quality evidence of effectiveness, except in conjunction with recommended treatments, including return to work, exercises, and medications. It may be recommended if pain is ineffectively controlled by medications. Medication intolerance, history of substance abuse, significant pain for postoperative conditions, worse than manipulated to perform exercise programs or physical therapy treatment or unresponsive to conservative measures are included in the criteria that interferential current stimulation units would be indicated for. There is lack of evidence in the documentation provided that reflect diminished effectiveness of medications, history of substance abuse, or any postoperative conditions that would limit the injured worker's ability to perform exercise programs or physical therapy treatment. It is unclear if the injured worker was unresponsive to conservative measures. The requesting physician did not include an adequate and complete assessment of the injured worker's objective functional condition that would demonstrate deficits needing to be addressed as well as establish a baseline by which assess objective functional improvement over the course of therapy. Additionally, the provider's request does not indicate the site at which the stim care unit is indicated for, and the request is not clear as to if the stim care unit was to be purchased or rented.

