

Case Number:	CM15-0125570		
Date Assigned:	07/02/2015	Date of Injury:	11/19/2014
Decision Date:	07/31/2015	UR Denial Date:	06/10/2015
Priority:	Standard	Application Received:	06/29/2015

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: Emergency 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:

This is a 37 year old male with a November 19, 2014 date of injury. A progress note dated May 22, 2015 documents subjective complaints (sharp, burning, radicular neck pain rated at a level of 8/10; associated numbness and tingling of the bilateral upper extremities; dull, achy, radicular mid back pain rated at a level of 4-5/10; sharp, burning, radicular lower back pain rated at a level of 8-9/10; associated numbness and tingling of the bilateral lower extremities), objective findings (anterior head carriage with right lateral head tilt; tenderness to palpation at suboccipital and scalene muscles; decreased range of motion of the cervical spine; positive cervical compression test and maximal foraminal compression test; diminished sensation to light touch over the C5, C6, C7, C8, and T1 dermatomes in the upper extremities; decreased motor strength at C5, C6, C7, C8, and T1 myotomes secondary to pain in the upper extremities; palpable tenderness noted over the T2 to T5 spinous processes; paraspinal muscle guarding; decreased range of motion of the thoracic spine; slightly decreased sensation to pinprick and light touch at T1-T12 bilaterally; lumbar spine pain with heel-toe walking; lumbar paraspinal muscle guarding; tenderness to palpation at the L3-L5 spinous processes and at the right quadratus lumborum muscle; decreased range of motion of the lumbar spine; positive straight leg raise bilaterally; positive Braggard's bilaterally; diminished sensation to pinprick and light touch at the L4, L5, and S1 dermatomes bilaterally; decreased motor strength at L2-L5 and S1 myotomes bilaterally in the lower extremities), and current diagnoses (cervical spine radiculopathy; cervical spine pain; cervical disc displacement; thoracic spine pain; rule out thoracic spine herniated nucleus pulposus; lower back pain; lower extremity radiculitis; lumbar disc displacement herniated nucleus pulposus).

Treatments to date have included medications, physical therapy, acupuncture, shock wave therapy, and Localized Intense Neurostimulation therapy. The medical record indicates that medications offer temporary relief of pain and improve ability to have restful sleep. The treating physician documented a plan of care that included physical therapy for the cervical, thoracic, and lumbar spine, acupuncture for the cervical, thoracic, and lumbar spine, and a transcutaneous electrical nerve stimulator unit for home use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3xwk x 6 wks Cervical spine, Thoracic spine, and Lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The requested Physical therapy 3xwk x 6 wks Cervical spine, Thoracic spine, and Lumbar spine, is not medically necessary. CA MTUS 2009, Chronic Pain Medical Treatment Guidelines, Physical Medicine, Page 98-99, recommend continued physical therapy with documented objective evidence of derived functional improvement. The injured worker has subjective complaints (sharp, burning, radicular neck pain rated at a level of 8/10; associated numbness and tingling of the bilateral upper extremities; dull, achy, radicular mid back pain rated at a level of 4-5/10; sharp, burning, radicular lower back pain rated at a level of 8-9/10; associated numbness and tingling of the bilateral lower extremities), objective findings (anterior head carriage with right lateral head tilt; tenderness to palpation at suboccipital and scalene muscles; decreased range of motion of the cervical spine; positive cervical compression test and maximal foraminal compression test; diminished sensation to light touch over the C5, C6, C7, C8, and T1 dermatomes in the upper extremities; decreased motor strength at C5, C6, C7, C8, and T1 myotomes secondary to pain in the upper extremities; palpable tenderness noted over the T2 to T5 spinous processes; paraspinal muscle guarding; decreased range of motion of the thoracic spine; slightly decreased sensation to pinprick and light touch at T1-T12 bilaterally; lumbar spine pain with heel-toe walking; lumbar paraspinal muscle guarding; tenderness to palpation at the L3-L5 spinous processes and at the right quadratus lumborum muscle; decreased range of motion of the lumbar spine; positive straight leg raise bilaterally; positive Braggard's bilaterally; diminished sensation to pinprick and light touch at the L4, L5, and S1 dermatomes bilaterally; decreased motor strength at L2-L5 and S1 myotomes bilaterally in the lower extremities), and current diagnoses (cervical spine radiculopathy; cervical spine pain; cervical disc displacement; thoracic spine pain; rule out thoracic spine herniated nucleus pulposus; lower back pain; lower extremity radiculitis; lumbar disc displacement herniated nucleus pulposus). The treating physician has not documented objective evidence of derived functional improvement from completed physical therapy sessions, nor the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program. The criteria noted above not having been met, Physical therapy 3xwk x 6 wks Cervical spine, Thoracic spine, and Lumbar spine is not medically necessary.

Acupuncture 3 x wk x 6 wks Cervical spine, Thoracic spine and Lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The requested Acupuncture 3 x wk x 6 wks Cervical spine, Thoracic spine and Lumbar spine, is not medically necessary. CA MTUS Acupuncture Guidelines recommend note that in general acupuncture "may be used as an adjunct to physical rehabilitation." The injured worker has subjective complaints (sharp, burning, radicular neck pain rated at a level of 8/10; associated numbness and tingling of the bilateral upper extremities; dull, achy, radicular mid back pain rated at a level of 4-5/10; sharp, burning, radicular lower back pain rated at a level of 8-9/10; associated numbness and tingling of the bilateral lower extremities), objective findings (anterior head carriage with right lateral head tilt; tenderness to palpation at suboccipital and scalene muscles; decreased range of motion of the cervical spine; positive cervical compression test and maximal foraminal compression test; diminished sensation to light touch over the C5, C6, C7, C8, and T1 dermatomes in the upper extremities; decreased motor strength at C5, C6, C7, C8, and T1 myotomes secondary to pain in the upper extremities; palpable tenderness noted over the T2 to T5 spinous processes; paraspinal muscle guarding; decreased range of motion of the thoracic spine; slightly decreased sensation to pinprick and light touch at T1-T12 bilaterally; lumbar spine pain with heel-toe walking; lumbar paraspinal muscle guarding; tenderness to palpation at the L3-L5 spinous processes and at the right quadratus lumborum muscle; decreased range of motion of the lumbar spine; positive straight leg raise bilaterally; positive Braggard's bilaterally; diminished sensation to pinprick and light touch at the L4, L5, and S1 dermatomes bilaterally; decreased motor strength at L2-L5 and S1 myotomes bilaterally in the lower extremities), and current diagnoses (cervical spine radiculopathy; cervical spine pain; cervical disc displacement; thoracic spine pain; rule out thoracic spine herniated nucleus pulposus; lower back pain; lower extremity radiculitis; lumbar disc displacement herniated nucleus pulposus). The treating physician has not documented objective evidence of derived functional benefit from completed acupuncture sessions, such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention. The criteria noted above not having been met, Acupuncture 3 x wk x 6 wks Cervical spine, Thoracic spine and Lumbar spine is not medically necessary.

Transcutaneous electrical nerve stimulation (TENS) unit with supplies for home use:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic, (transcutaneous electrical nerve stimulation) Page(s): 114-116.

Decision rationale: The requested Transcutaneous electrical nerve stimulation (TENS) unit with supplies for home use, is not medically necessary. Chronic Pain Medical Treatment Guidelines, TENS, chronic, (transcutaneous electrical nerve stimulation), pages 114 - 116, note "Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration." The injured worker has subjective complaints (sharp, burning, radicular neck pain rated at a level of 8/10; associated numbness and tingling of the bilateral upper extremities; dull, achy, radicular mid back pain rated at a level of 4-5/10; sharp, burning, radicular lower back pain rated at a level of 8-9/10; associated numbness and tingling of the bilateral lower extremities), objective findings (anterior head carriage with right lateral head tilt; tenderness to palpation at suboccipital and scalene muscles; decreased range of motion of the cervical spine; positive cervical compression test and maximal foraminal compression test; diminished sensation to light touch over the C5, C6, C7, C8, and T1 dermatomes in the upper extremities; decreased motor strength at C5, C6, C7, C8, and T1 myotomes secondary to pain in the upper extremities; palpable tenderness noted over the T2 to T5 spinous processes; paraspinal muscle guarding; decreased range of motion of the thoracic spine; slightly decreased sensation to pinprick and light touch at T1-T12 bilaterally; lumbar spine pain with heel-toe walking; lumbar paraspinal muscle guarding; tenderness to palpation at the L3-L5 spinous processes and at the right quadratus lumborum muscle; decreased range of motion of the lumbar spine; positive straight leg raise bilaterally; positive Braggard's bilaterally; diminished sensation to pinprick and light touch at the L4, L5, and S1 dermatomes bilaterally; decreased motor strength at L2-L5 and S1 myotomes bilaterally in the lower extremities), and current diagnoses (cervical spine radiculopathy; cervical spine pain; cervical disc displacement; thoracic spine pain; rule out thoracic spine herniated nucleus pulposus; lower back pain; lower extremity radiculitis; lumbar disc displacement herniated nucleus pulposus). The treating physician has not documented a current rehabilitation program, nor objective evidence of functional benefit from electrical stimulation under the supervision of a licensed physical therapist nor home use. The criteria noted above not having been met, Transcutaneous electrical nerve stimulation (TENS) unit with supplies for home use is not medically necessary.