

<b>Case Number:</b>	CM14-0151105		
<b>Date Assigned:</b>	10/01/2014	<b>Date of Injury:</b>	04/05/2006
<b>Decision Date:</b>	11/04/2014	<b>UR Denial Date:</b>	09/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 36-year-old female who reported an injury on 04/05/2006. The mechanism of injury was twisting. The injured worker's diagnoses included sciatica, meniscus disc, and myofasciitis. The injured worker's past treatments included an injection and medications. The injured worker's diagnostic testing included an MRI of the lumbar spine which revealed effusion and L5-S1 foraminal stenosis. An MRI of the left knee was noted to reveal a medial meniscal tear, ACL tear, osteoarthritis, and a popliteal cyst. The injured worker's surgical history included a knee surgery. On 08/12/2014, the injured worker complained of low back and left leg pain. He reported the knee pain a 5-8/10 and the low back pain a 4/10. On physical examination, the injured worker was documented to have decreased lumbar spine range of motion, and a painful cyst medially on the left knee. The injured worker's medications included ibuprofen. The request was for physical therapy x12 for the lumbar spine and TENS unit purchase. The rationale for the request was not provided. The Request for Authorization form was signed and submitted on 08/12/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy, 12 sessions, lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Lumbar Chapter: Physical/Occupational Therapy

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

**Decision rationale:** The request for physical therapy x12, lumbar spine is not medically necessary. The California MTUS Guidelines may recommend physical therapy 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. Therapy requires an internal effort by the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapy at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise without mechanical assistance or resistance in functional activities with assistive devices. The guidelines recommend treatment up to 10 visits over 8 weeks. The injured worker did complain of pain and had a history of knee surgery and L3-5 fusion. Although the injured worker was noted with decreased range of motion to the lumbar spine, the documentation did not provide evidence of significant objective functional limitations, like the inability to independently complete activities of daily living. In the absence of documentation with evidence of significant objective functional deficits, the request is not supported. Therefore, the request is not medically necessary.

**TENS Unit purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS ; Criteria for the use of TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

**Decision rationale:** The request for TENS unit purchase is not medically necessary. The California MTUS Guidelines state that a TENS unit is not recommended 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. While TENS may reflect the longstanding accepted standard of care within many medical communities, the results of studies are inconclusive. The published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long term effectiveness. Several published evidence- based assessments of transcutaneous electrical nerve stimulation has found that evidence is lacking concerning the effectiveness. The criteria for the use of TENS unit is documentation of pain of at least 3 months duration, evidence that other appropriate pain modalities have been tried including medication and failed, a one month trial period of a TENS unit should be documented with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. A rental would be preferred over purchase during this trial. The documentation did not indicate the patient has tried a one month trial of the TENS unit with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. The documentation did not provide evidence that the injured worker was participating or had documented intent to participate in an adjunct program of evidence based functional restoration.

In the absence of documentation with evidence of other appropriate pain modalities having been tried and failed including medication, documented evidence of a one month trial period of the TENS unit, and documented evidence that the injured worker is participating or has intent to participate in a program of evidence based functional restoration, the request is not supported. Therefore, the request is not medically necessary.