

<b>Case Number:</b>	CM13-0031566		
<b>Date Assigned:</b>	12/04/2013	<b>Date of Injury:</b>	01/14/2010
<b>Decision Date:</b>	02/13/2014	<b>UR Denial Date:</b>	09/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 physician 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:

This is a male patient with the date of injury of January 14, 2010. A utilization review determination dated September 18, 2013 recommends certification of MRI of lumbar spine and non-certification of chiropractic manipulation and hot & cold unit. The previous reviewing physician recommended non-certification of chiropractic manipulation due to lack of documentation of an acute exacerbation of the patient's chronic pain, functional benefits from sessions in the past, and the number of sessions completed. Non-certification of the hot & cold unit was recommended due to lack of evidence based guidelines support for the clinical efficacy of combined motorized hot and cold units. A PR-2 report dated October 17, 2013 identifies subjective complaints of low back pain radiating to the lower extremities with numbness and tingling 6/10. Objective findings identify decreased lumbar range of motion, SLR positive bilaterally, and tender lumbar spine. Diagnoses include neck sprain/strain, status post lumbar surgery July 2009, bilateral shoulder internal derangement, and bilateral elbow internal derangement. Treatment plan identifies the patient is being evaluated for medication management and/or ongoing medication therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic manipulation 2 x 4 weeks for lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, 303-304, Chronic Pain Treatment Guidelines Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

**Decision rationale:** Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion.

**DME (hot and cold unit) for lumbar spine rental for 6 months:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Cold/Heat Packs

**Decision rationale:** Regarding the request for DME (hot and cold unit) for lumbar spine rental for 6 months, Occupational Medicine Practice Guidelines state physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Official Disability Guidelines (ODG) state cold/heat packs are recommended as an option for acute pain. Within the medical information made available for review, the patient is noted to have chronic pain. There is no documentation of acute pain. In the absence of such documentation, and given evidence based guidelines lack of support for hot/cold therapy units in the management of chronic pain, the currently requested DME (hot and cold unit) for lumbar spine rental for 6 months is not medically necessary.