

Case Number:	CM14-0001520		
Date Assigned:	01/22/2014	Date of Injury:	06/30/2000
Decision Date:	03/25/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/04/2014

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 female patient with a date of injury of June 30, 2000. A utilization review determination dated December 30, 2013 recommends noncertification of chiropractic care, cold pneumatic compression, TENS, brace, and heat pad. A progress note dated November 20, 2013 includes subjective complaints of neck pain, low back pain, bilateral shoulder pain, and bilateral wrist/hand pain. Physical examination identifies tenderness in the cervical and lumbar spine with intact sensation. Diagnoses include status post lumbar spinal fusion, status post right shoulder surgery, cervical spine disc bulge, status post right carpal tunnel surgery, left shoulder internal derangement, left carpal tunnel syndrome, and other problems unrelated to current evaluation. The treatment plan recommends epidural injection, aquatic therapy, chiropractic therapy 2 times a week for 6 weeks, TENS unit, cold pneumatic compression, lumbar brace, heat pad, and pain management consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment twice weekly for (6) weeks QTY: 12.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59.

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

Decision rationale: Regarding the request for chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, it is unclear exactly what objective functional deficits are intended to be addressed with the currently requested chiropractic care. Additionally, the currently requested 12 treatment sessions exceeds the initial trial recommended by guidelines of 6 visits. In the absence of clarity regarding the above issues, the currently requested chiropractic care is not medically necessary.

Cold pneumatic compression therapy unit QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

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), Knee & Leg, Compression Garments, Low Back Chapter, Cold/Heat Packs

Decision rationale: Regarding the request for a cold pneumatic compression therapy, California MTUS and ODG do not specifically address the issue for the low back, although ODG supports cold therapy units for up to 7 days after surgery for some other body parts. For the back, CA MTUS/ACOEM and ODG recommend the use of cold packs for acute complaints. Guidelines support the use of low-tech applications of ice packs at home. Guideline to not support the use of compression therapy for chronic low back pain. Within the documentation available for review, there is no documentation of a rationale for the use of a formal cold therapy unit rather than the application of simple cold packs at home during the initial postoperative period. Additionally, there is no rationale for compression therapy, and no scientific literature provided to support its use for this patient's diagnoses. In the absence of clarity regarding those issues, the currently requested cold pneumatic compression therapy is not medically necessary

TENS unit QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: Regarding the request for TENS, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is 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. Guidelines recommend failure of other appropriate pain modalities including

medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach, with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Within the documentation available for review, there is no indication that the patient has undergone a TENS unit trial, and no documentation of any specific objective functional deficits which a tens unit trial would be intended to address. Additionally, it is unclear what other treatment modalities are currently being used within a functional restoration approach. In the absence of clarity regarding those issues, the currently requested TENS unit is not medically necessary.

Lumbar brace QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Lumbar Supports

Decision rationale: Regarding the request for lumbar brace, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states that lumbar supports are not recommended for prevention. They go on to state the lumbar support are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. ODG goes on to state that for nonspecific low back pain, compared to no lumbar support, elastic lumbar belt maybe more effective than no belt at improving pain at 30 and 90 days in people with subacute low back pain lasting 1 to 3 months. However, the evidence was very weak. Within the documentation available for review, it does not appear that this patient is in the acute or subacute phase of his treatment. Additionally, there is no documentation indicating that the patient has a diagnosis of compression fracture, spondylolisthesis, or instability. As such, the currently requested lumbar brace is not medically necessary.

Heat pad QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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 a heat pad, Occupational Medicine Practice Guidelines state that various modalities such as heating have insufficient testing to determine their effectiveness, but they may have some value in the short term if used in conjunction with the program of functional restoration. ODG states that heat/cold packs are recommended as an option for acute pain. Within the documentation available for review, and there is no indication

that the patient has acute pain. Additionally, it is unclear what program of functional restoration the patient is currently participating in which would be used alongside the currently requested heat pad. In the absence of clarity regarding those issues, the currently requested keypad is not medically necessary.