

<b>Case Number:</b>	CM14-0103975		
<b>Date Assigned:</b>	08/11/2014	<b>Date of Injury:</b>	03/24/2014
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	06/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2014

### 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 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 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:

This is a female patient with the date of injury of March 24, 2014. A Utilization Review was performed on June 17, 2014 and recommended non-certification of ECSWT bilateral wrist, physical performance FCE, DME: Lumbosacral Brace, interferential unit, hot and cold unit, and physical therapy eval & tx elbows and bilateral wrists and hands. A Progress Note dated May 27, 2014 identifies Physical Examination of tenderness in the cervical paraspinal, positive Tinel's sign at the wrists bilaterally, positive Compression test, restricted cervical range of motion, 4/5 right upper and lower extremity strength, decreased sensation in the median distribution and the right anterolateral thigh, and positive impingement signs of the right shoulder. Diagnoses identify cervical, lumbar, and thoracic strains, shoulder strain, elbow and wrist sprains. Treatment to date and Treatment Plan are unspecified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ECSWT (Extracorporeal shock wave therapy) for bilateral wrist: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation  
[http://www.cigna.com/customer\\_care/healthcare\\_professional/coverage\\_positions/medical/mm\\_0004\\_coveragepositioncriteria\\_eswt\\_for\\_musculoskelatel\\_conditions.pdf](http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/medical/mm_0004_coveragepositioncriteria_eswt_for_musculoskelatel_conditions.pdf)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Anthem Medical Policy # SURG.00045 Extracorporeal Shock Wave Therapy for Orthopedic Conditions

**Decision rationale:** The Anthem medical policy notes that ESWT for the treatment of musculoskeletal conditions is considered investigational and not medically necessary. In light of the above issues, the currently requested ECSWT (Extracorporeal shock wave therapy) is not medically necessary.

**Physical performance FCE (Functional Capacity Evaluation):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines Chapter 7 Independent Medical Evaluations and Consultations

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 12. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter, Functional Capacity Evaluation

**Decision rationale:** The ACOEM Guidelines state that there is no good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. The ODG states that functional capacity evaluations are recommended prior to admission to a work hardening program. The criteria for the use of a functional capacity evaluation includes case management being hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed explanation of a worker's abilities. Additionally, guidelines recommend that the patient be close to or at maximum medical improvement with all key medical reports secured and additional/secondary conditions clarified. Within the documentation available for review, there is no indication that there has been prior unsuccessful return to work attempts, conflicting medical reporting, or injuries that would require detailed exploration. In the absence of clarity regarding those issues, the currently requested physical performance FCE (functional capacity evaluation) is not medically necessary.

**Lumbosacral brace:** 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): 301. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) Low Back Chapter, Lumbar Supports

**Decision rationale:** Regarding the request for lumbosacral 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 supports are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. The 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 lumbosacral brace is not medically necessary.

**Interferential Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Interferential Current Stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 118-120 OF 127.

**Decision rationale:** The MTUS Chronic Pain Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested interferential unit is not medically necessary.

**Hot and cold unit:** 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:** The ACOEM 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. The 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 hot and cold unit. In the absence of clarity regarding those issues, the currently requested hot and cold unit is not medically necessary.

**Physical therapy evaluation and treatment for the cervical spine, thoracic spine, lumbar spine, both shoulders, both wrists, both hands and elbows, 2 times a week for 6 weeks,**

**QTY: 12 sessions:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 98-99 of 127 Physical Medicine Pa.

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of 6 physical therapy sessions. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, the patient does present with functional deficits. An initial course of physical therapy may be appropriate. However, the request exceeds the amount of PT recommended by the MTUS Guidelines. In the absence of such documentation, the current request is not medically necessary.