

<b>Case Number:</b>	CM14-0015054		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	01/04/2012
<b>Decision Date:</b>	07/22/2014	<b>UR Denial Date:</b>	02/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2014

### 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 and is licensed to practice in Minnesota. 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 51-year-old male who reported an injury on 01/04/2012. The mechanism of injury was not provided for clinical review. The diagnoses included lumbar radiculopathy, cervical spine strain, left greater trochanteric bursitis, left knee internal derangement, gastropathy, and hypertension. Previous treatments included physical therapy, chiropractic care, stretching and hip strengthening exercises, medication, epidural steroid injections, NCS and EMG. Within the clinical note dated 01/13/2014, reported the injured worker complained of increased lower back and left lower extremity pain. Upon the physical examination of the cervical spine, the provider noted the paravertebral muscles were tender, spasms were present. The range of motion was restricted. Deep tendon reflexes are normal. Sensation is intact. The lumbar spine revealed the paravertebral muscles were tender and spasms are present. The range of motion of the lumbar spine was restricted. The provider noted the injured worker had a positive straight leg raise on the left. The provider indicated sensation is reduced in the left L5 dermatomal distribution. The left knee joint line had tenderness to palpation, with a positive McMurray's test. The provider requested a heating pad, home exercise kit, and physical therapy. However, a rationale was not provided for clinical review. The request for authorization was submitted and dated on 01/13/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**HEATING PAD:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**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, Heat Therapy.

**Decision rationale:** The request for a heating pad is not medically necessary. The injured worker complained of increased lower back and left lower extremity pain. The California MTUS/American College of Occupational and Environmental Medicine recommend a home and local application of heat or cold are as effective as those performed by therapists. The Official Disability Guidelines recommend heat therapy as an option. A number of studies show continuous low level heat wrap therapy to be effective for heating low back pain. The guidelines also state that the combination of continuous low level heat wrap therapy and exercise significantly improves functional outcomes in the treatment of low back pain. In addition, there is moderate evidence that heat wrap therapy provides a small short term reduction in pain and disability and acute and subacute low back pain and that the addition of exercise further reduces pain and improved function. The request submitted does not specify the treatment site. The provider's rationale for the use of a heating pad was not provided for clinical review. There is lack of documentation warranting the medical necessity for the use of a heating pad. The request submitted failed to provide whether the provider indicated the injured worker to use the heating pad as a rental or a purchase. Therefore, the request for a heating pad is not medically necessary.

**HOME EXERCISE KIT:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Durable Medical Equipment.

**Decision rationale:** The request for a home exercise kit is not medically necessary. The injured worker complained of increased lower back and left lower extremity pain. The Official Disability Guidelines recommend durable medical equipment generally if there is a medical need and if the device or system meets Medicare definitions of durable medical equipment. The guidelines note durable medical equipment provides therapeutic benefit or enables a member to perform certain tasks that he or she is unable to do otherwise due to a medical condition or illness, and can withstand repeated use. The guidelines note it is primarily and customarily used to serve a medical purpose, generally is not useful for a person in the absence of illness or injury, and is appropriate for use in the patient's home. There is lack of documentation indicating the home exercise kit will improve the injured worker's ability to perform her activities of daily living. The provider failed to document the type of home exercise kit he is requesting. There is lack of documentation indicating the treatment site for the home exercise kit. There is lack of documentation indicating the length of time the injured worker is to utilize the home exercise kit. Therefore, the request for a home exercise kit is not medically necessary.

**PHYSICAL THERAPY FOR THE NECK AND LEFT HIP, THREE TIMES FOUR QUANTITY. 12.00:** Upheld

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

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

**Decision rationale:** The request for physical therapy for the neck and left hip 3 times a week for 4 weeks, quantity 12 visits, is non-certified. The injured worker complained of increased lower back and left lower extremity pain. The California MTUS Guidelines state that active therapy is 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. Active therapy requires an internal effort by the individual to complete a specific task or exercise. The guidelines note injured workers are instructed and expected to continue active therapies at home as an extension of treatment process in order to maintain increased functional ability. The guidelines recommend for neuralgia or myalgia 8 to 10 visits of physical therapy are recommended. There is lack of documentation indicating the injured worker's prior course of physical therapy. There is lack of documentation indicating the injured worker's efficacy from the previous physical therapy as evidenced by significant functional improvement. The provider failed to document and adequate and complete physical examination demonstrating the injured worker had decreased functional ability, decreased range of motion, and decreased strength or flexibility. The request submitted of 12 visits exceeds the guideline recommendations of 8 to 10 visits. Therefore, the request for physical therapy for the neck and left hip 3 times a week for 4 weeks quantity 12 is non-certified.