

Case Number:	CM14-0159095		
Date Assigned:	10/02/2014	Date of Injury:	06/21/2012
Decision Date:	10/28/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	09/29/2014

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 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:

According to the records made available for review, this is a 29-year-old female with a 6/21/12 date of injury. At the time (7/22/14) of request for authorization for 8 visits of physical therapy for the neck, thoracic, and lumbar spine; purchase of an aqua relief system; Lumbar traction unit; Cervical traction unit; LSO back brace; Lumbar exercise kit; and 30 day trial of H-Wave unit, there is documentation of subjective (neck pain radiating to the shoulders and low back pain radiating to the hips and right lower extremity) and objective (positive Spurling's test, decreased cervical and lumbar spine range of motion, tenderness to palpation and spasm over the cervical, thoracic, and lumbar spine, antalgic gait, positive straight leg raise on the right, decreased sensation over the L5 and S1 dermatomes, positive impingement sign bilaterally, and decreased shoulder range of motion) findings, current diagnoses (lumbar discopathy, thoracic myofascial strain, cervical mulculoligamentous injury, bilateral shoulder injury, cervicogenic headache, and anxiety and depression), and treatment to date (at least 24 previous physical therapy with temporary relief, injections, acupuncture, TENS unit, and medications). Medical report identifies chronic soft tissue inflammation; goal of trial to decrease the need for oral medication and improve the patient's ability to participate in increase ADLs and experience improved function. Regarding physical therapy, there is no documentation of remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date. Regarding LSO brace, there is no documentation of compression fractures, spondylolisthesis, or documented instability. Regarding lumbar exercise kit, there is no documentation that the patient has been taught appropriate home exercises by a therapist or

medical provider and a description of the exact contents of the kit. Regarding H-wave, there is no documentation of failure of additional conservative care (physical therapy).

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Physical Therapy Visits for The Neck, Thoracic, and Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation ACOEM, Pain, Suffering, and the Restoration of Function, page 114

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, and Low Back - Lumbar & Thoracic, Physical Therapy Title 8, California Code of Regulations

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. ODG recommends a limited course of physical therapy for patients with a diagnosis of sprains/strains of neck not to exceed 10 visits over 8 weeks and patients with a diagnosis of intervertebral disc disorder not to exceed 10 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of lumbar discopathy, thoracic myofascial strain, cervical mulculoligamentous injury, bilateral shoulder injury, cervicogenic headache, and anxiety and depression. In addition, there is documentation of previous physical therapy. However, given documentation of at least 24 physical sessions completed to date, which exceeds guidelines, there is no documentation of remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines. In addition, despite documentation of temporary relief with previous physical therapy, there is no (clear) documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for 8 Physical Therapy visits for the neck, thoracic, and lumbar spine is not medically necessary.

Purchase of an Aqua Relief System: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [http://paintechnology.com/products/water-therapy-systems/the-aqua-relief-system-\(hotcold-therapy-pump\)-1181](http://paintechnology.com/products/water-therapy-systems/the-aqua-relief-system-(hotcold-therapy-pump)-1181); and the Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Cold/heat packs PMID: 18214217 [PubMed - indexed for MEDLINE]

Decision rationale: MTUS reference to ACOEM guidelines identifies at-home applications of local heat or cold to the low back as an optional clinical measure for evaluation and management of low back complaints. ODG identifies that there is minimal evidence supporting the use of cold therapy. Medical Treatment Guideline identifies that exact recommendations on application time and temperature cannot be given. Therefore, based on guidelines and a review of the evidence, the request for purchase of an aqua relief system is not medically necessary.

Lumbar traction unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Traction

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: MTUS reference to ACOEM guidelines identifies that traction has not been proved effective for lasting relief in treating low back pain; and that because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Lumbar traction unit is not medically necessary.

Cervical traction unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

Decision rationale: MTUS reference to ACOEM guidelines identifies that traction is not recommended for managing neck and upper back complaints. Therefore, based on guidelines and a review of the evidence, the request for cervical traction unit is not medically necessary.

LSO back brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: MTUS reference to ACOEM identifies that lumbar support have not been shown to have any lasting benefit beyond acute phase of symptom relief. ODG identifies documentation of compression fractures, spondylolisthesis, or documented instability, as criteria necessary to support the medical necessity of lumbar support. Within the medical information available for review, there is documentation of a diagnosis of lumbar discopathy. However, there is no documentation of compression fractures, spondylolisthesis, or documented instability. Therefore, based on guidelines and a review of the evidence, the request for LSO back brace is not medically necessary.

Lumbar exercise kit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee chapter, Exercise equipment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Exercise and Knee & Leg, Home Exercise Kit

Decision rationale: MTUS does not address the issue. ODG identifies that there is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise; that there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen; that a therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated; and that such programs should emphasize education, independence, and the importance of an on-going exercise regime. In addition, ODG identifies a home exercise kit is recommended as an option where home exercise programs are recommended; that the patient has been taught appropriate home exercises by a therapist or medical provider and a description of the exact contents of the kit. Within the medical information available for review, there is documentation of a diagnosis of lumbar discopathy. However, there is no documentation that the patient has been taught appropriate home exercises by a therapist or medical provider and a description of the exact contents of the kit. Therefore, based on guidelines and a review of the evidence, the request for Lumbar exercise kit is not medically necessary.

30 Day Trial of H-Wave Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back Complaints Page(s): 117-118.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that a one-month home-based trial of H-Wave stimulation may be considered as a noninvasive conservative option for chronic soft tissue inflammation used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies that the effects and benefits of the one month trial should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function. Within the medical information available for review, there is documentation of diagnoses of lumbar discopathy, thoracic myofascial strain, cervical mulculoligamentous injury, bilateral shoulder injury, cervicogenic headache. In addition, there is documentation of chronic soft tissue inflammation used as an adjunct to a program of evidence-based functional restoration, and failure of conservative care (medications and transcutaneous electrical nerve stimulation (TENS)). However, given documentation of an associated request for physical therapy, there is no documentation of failure of additional conservative care (physical therapy). Therefore, based on guidelines and a review of the evidence, the request for and 30 day trial of H-Wave unit is not medically necessary.