

Case Number:	CM14-0161272		
Date Assigned:	10/06/2014	Date of Injury:	09/12/2013
Decision Date:	11/20/2014	UR Denial Date:	09/10/2014
Priority:	Standard	Application Received:	10/01/2014

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 & Rehabilitation 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 65-year-old female with a 9/12/13 date of injury. At the time (7/29/14) of request for authorization for Multi-Stim unit and supplies, Solace interferential (IF) unit monthly rental for 30 minutes 3-5 times daily, Home exercise kit, and Donut purchase, there is documentation of subjective (neck and low back pain) and objective (restricted cervical and lumbar range of motion, decreased upper and extremity motor strength, and positive bilateral straight leg raise) findings, current diagnoses (cervical/lumbar radiculopathy and cervical/lumbar intervertebral disc syndrome), and treatment to date (medications, physical therapy, and acupuncture treatment). Medical report identifies a request for multi-stem unit and supplies for low back pain; Solace IF to help in pain reduction, reduction of edema, and/or accelerate rehabilitation as an adjunct to conservative treatment, as part of the functional restoration program; home exercise kit to help in strengthening and to improve neck and back range of motion; and a request for donut so that patient could sit for longer periods of time without experiencing back pain. Regarding Solace interferential (IF) unit monthly rental for 30 minutes 3-5 times daily, there is no documentation that the IF unit will be used in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended. Regarding Home exercise kit, there is no documentation of a rationale to justify the use of home exercise kit over any other exercise regimen; and 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.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multi-Stim unit and supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) Page(s): 116.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) and Interferential Current Stimulation (ICS).

Decision rationale: MTUS reference to ACOEM identifies that physical modalities, such as transcutaneous electrical neurostimulation (tens) units, have no scientifically proven efficacy in treating low back symptoms. MTUS chronic pain medical treatment guidelines identifies that interferential current stimulation (ICS), microcurrent electrical stimulation (MENS devices), and neuromuscular electrical stimulation (NMES devices) are not recommended. Therefore, based on guidelines and a review of the evidence, the request for Multi-Stim unit and supplies is not recommended.

Solace interferential (IF) unit monthly rental for 30 minutes 3-5 times daily: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that interferential current stimulation is not recommended as an isolated intervention and that there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Within the medical information available for review, there is documentation of diagnoses of cervical/lumbar radiculopathy and cervical/lumbar intervertebral disc syndrome. However, documentation that the requested IF unit is to be used as an adjunct to conservative treatment, as part of the functional restoration program, there is no documentation that the IF unit will be used in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Therefore, based on guidelines and a review of the evidence; the request for Solace interferential (IF) unit monthly rental for 30 minutes 3-5 times daily is not medically necessary.

Home exercise kit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Exercise; Neck & Upper Back and Low Back Chapter, 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 diagnoses of cervical/lumbar radiculopathy and cervical/lumbar intervertebral disc syndrome. In addition, there is documentation of a request for home exercise kit to help in strengthening and to improve neck and back range of motion. However, there is no documentation of a rationale to justify the use of home exercise kit over any other exercise regimen. In addition, 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 Home exercise kit is not medically necessary.

Donut purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back, Lumbar Supports

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: <http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions>

Decision rationale: MTUS and ODG do not address this issue. Medical Treatment Guideline identifies documentation that the request represents medical treatment in order to be reviewed for medical necessity, as criteria necessary to support the medical necessity of the requested donut purchase. Within the medical information available for review, there is documentation of diagnoses of cervical/lumbar radiculopathy and cervical/lumbar intervertebral disc syndrome. However, there is no documentation that the request represents medical treatment that should be reviewed for medical necessity. Therefore, based on guidelines and a review of the evidence, the request for Donut purchase is not medically necessary.