MAXIMUS Federal Services

Case Number:	CM14-0173454		
Date Assigned:	10/24/2014	Date of Injury:	07/01/2013
Decision Date:	12/09/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	10/21/2014

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 Occupational 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:

This is a 53 year-old male who has reported low back, upper extremity, and right knee pain after an injury on 7/1/13. Diagnoses have included lumbar strain, degenerative disc disease, carpal tunnel syndrome, left thumb osteoarthritis, and knee degenerative joint disease. Treatment has included left thumb surgery for arthritis, left carpal tunnel release, and occupational therapy. The records are from 3/26/14 to 10/1/13. Reports refer to prescribing of physical therapy, but without any discussion of specific quantities and results. The reports briefly refer to ongoing low back and upper extremity symptoms. None of the available reports from the treating physicians address the medical necessity for any of the items now under Independent Medical Review.On 9/16/14 Utilization Review non-certified the full requests now under Independent Medical Review. The physical therapy request was partially certified, noting the lack of evidence for prior physical therapy. The MTUS and the Official Disability Guidelines were cited in support of the decisions.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Lumbosacral brace: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 9; 308. Decision based on Non-MTUS Citation ACOEM Guidelines, Update 4/7/08, Low Back Chapter, Lumbar Supports page 138.

Decision rationale: The ACOEM Guidelines do not recommend lumbar binders, corsets, or support belts as treatment for low back pain, see page 308. On Page 9 of the Guidelines, "The use of back belts as lumbar support should be avoided because they have been shown to have little or no benefit, thereby providing only a false sense of security." The updated ACOEM Guidelines likewise do not recommend lumbar braces for treatment of low back pain. The lumbar brace is therefore not medically necessary.

1 Interferential Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 119. Decision based on Non-MTUS Citation ACOEM Guidelines, Chronic Pain Update 8/14/08, Page 189; ACOEM Guidelines update, 4/7/08, Low Back, page 166

Decision rationale: The ACOEM guidelines, 2004 version and the updated chapters cited above, do not recommend interferential therapy for any pain or injury conditions. The MTUS for Chronic Pain provides very limited support for interferential treatment, notes the poor quality of medical evidence in support of interferential stimulation therapy, and states that there is insufficient evidence for using interferential stimulation for wound healing or soft tissue injury. The treating physician has not provided a treatment plan which includes interferential stimulation therapy in the context of the recommendations of the MTUS. This includes return to work, exercise, medications, and no conductive garment. The interferential unit is not medically necessary based on lack of medical evidence, guidelines, and a treatment plan in accordance with guidelines.

1 Hot and cold unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 48; 299-300, 308. Decision based on Non-MTUS Citation ACOEM Guidelines, Updated Chronic Pain Section, Page 166, 168; Heat and Cold Therapies.

Decision rationale: The MTUS for Chronic Pain does not provide direction for the use of heat or cold to treat chronic pain. The ACOEM Guidelines pages 299-300 recommend application of heat or cold for low back pain. At-home applications of heat or cold are as effective as those performed by therapists. Page 308 recommends home application of heat or cold. There is no

recommendation for any specific device in order to accomplish this. Heat and cold can be applied to the skin using simple home materials, e.g. ice and hot water, without any formal medical device or equipment. Per Page 48 of the Guidelines, heat or cold may be used for two weeks or less. This patient's condition is long past the two-week duration. The updated ACOEM Guidelines for Chronic Pain are also cited. There may be some indication for heat therapy, but the recommendation is for home application of non-proprietary, low-tech, heat therapy in the context of functional restoration. There is no evidence of any current functional restoration program. The treating physician has not provided any information in support of the specific devices prescribed for this patient. The cold and heat device prescribed for this patient is not medically necessary based on the MTUS, other guidelines, and lack of a sufficient treatment plan. Therefore, Hot and cold unit is not medically necessary and appropriate.

1 right knee sleeve: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340, 346.

Decision rationale: The ACOEM Guidelines page 340 state that a knee brace can be used for patellar instability, ACL tear, or MCL instability, although its benefits may be more related to increasing the patient's confidence than strictly medical. A brace would usually be needed if the patient will be stressing the knee under load, such as climbing or carrying. For the average patient, using a brace is usually unnecessary. In all cases, braces need to be properly fitted and combined with a rehabilitation program. On page 338, a knee sleeve is an option for patellofemoral syndrome. On Page 346, the guidelines recommend short duration immobilization after acute injury, and functional bracing as part of rehab program. In this case, there are no reports from the treating physician discussing the kind of brace prescribed or the specific indications. The indications in the MTUS were not listed. The brace is therefore not medically necessary.

12 sessions of Physical therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, Functional Improvement; Physical Medicine Page(s): 9; 98-99.

Decision rationale: The records do not contain a sufficient prescription from the treating physician, which must contain diagnosis, duration, frequency, and treatment modalities, at minimum. Per the MTUS, Chronic Pain section, functional improvement is the goal rather than the elimination of pain. The maximum recommended quantity of Physical Medicine visits is 10, with progression to home exercise. It is not clear what is intended to be accomplished with this physical therapy, given that it will not cure the pain and there are no other goals of therapy. The

current physical therapy prescription exceeds the quantity recommended in the MTUS. Physical Medicine for chronic pain should be focused on progressive exercise and self-care, with identification of functional deficits and goals, and minimal or no use of passive modalities. A non-specific prescription for physical therapy in cases of chronic pain is not sufficient. The prescribed Physical Medicine is not medically necessary based on the MTUS, lack of an explicit emphasis on functional improvement, and the lack of a sufficient prescription.