MAXIMUS Federal Services

Case Number:	CM14-0027912		
Date Assigned:	06/20/2014	Date of Injury:	05/10/2012
Decision Date:	07/31/2014	UR Denial Date:	02/06/2014
Priority:	Standard	Application Received:	03/05/2014

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 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:

The injured worker is a 59-year-old female who reported an injury on 05/10/2012 while working in a school district. The injured worker indicated that consequently, she developed pain to various bodily regions, including her neck, left shoulder, and middle and lower back. Physical examination on 02/13/2014 revealed complaints of neck pain. The pain was rated at 9/10 on the VAS scale without medications, and at 4/10 with medications. Neck movements aggravated the pain and it was relieved with rest and medications. The left shoulder pain was rated at a 9/10 on the VAS scale without medications, and at 4/10 with medications. The pain was aggravated by activities such as overhead reaching, lifting, and was relieved with rest and medications. The injured worker also had complaints of low back pain rated at 10/10 on the VAS scale without medications, and at 4/10 with medications. The pain was aggravated by activities such as bending, lifting, and it was relieved with rest and medications. The injured worker stated low back pain was associated with radiating pain to both lower extremities, more on the left side. There also was complaint of middle back pain rated at 8/10 on the VAS scale without medications, and at 4/10 with medications. The pain was aggravated by activities such as bending, lifting, and it was relieved with rest and medications. Cervical spine exam showed tenderness and myospasm palpable over bilateral paracervical muscle and bilateral trapezius muscles. The Spurling's and cervical distraction test were bilaterally positive. There was decreased cervical range of motion on all planes due to neck pain. Flexion was to 45 degrees, extension was to 50 degrees, right rotation was to 75 degrees, left rotation was to 75 degrees, right lateral bending was to 40 degrees, and left lateral bending was to 40 degrees. Thoracic spine and upper back exam revealed parathoracic myospasm bilaterally present from T1 through T12 spinal levels. There was decreased thoracic range of motion, due to middle back pain. Flexion of the thoracic spine was to 55 degrees, right rotation was to 25 degrees, and left rotation

was to 25 degrees. Lumbar spine and lower back exam revealed tenderness and myospasm palpable over bilateral paralumbar muscles. Tenderness was also palpable in both sciatic notches. There was decreased lumbar range of motion in all planes. Flexion was to 45 degrees, extension was to 20 degrees, right rotation was to 20 degrees, left rotation was to 20 degrees, right lateral bending was to 20 degrees, and left lateral bending was to 20 degrees. Examination of the shoulder revealed tenderness palpable over the left acromioclavicular joint, left subacromial region, left greater tubercle, as well as tenderness and myospasm palpable over the left rotator cuff muscles. Impingement and supraspinatus test were both positive in the left shoulder. There was a decrease in the range of motion for the left shoulder. Abduction of the right was to 180, left was to 170; flexion on the right was to 180 degrees, flexion to the left was to 170 degrees; internal rotation of the right was to 90 degrees and to the left was to 80 degrees; external rotation of the right was to 90 degrees, to the left was to 80 degrees; extension of the right was to 50 degrees, to the left was to 40 degrees; and adduction to the right was to 50 degrees, to the left was to 45 degrees. The neurological examination revealed decreased sensation in the upper and lower extremities, including 2 joint discrimination, light touch, and pain sensations. Motor examination revealed reduced motor strength in the upper and lower extremity muscles. Medications for the injured worker were Terocin 240 ML; Genicin capsules; Somnicin capsules; Laxacin tablets; gabacyclotram; capsaicin, menthol, camphor, tramadol, gabapentin, and Cyclobenzaprine cream; Anaprox 550 mg; Soma 250 mg; and Protonix 20 mg. Diagnoses for the injured worker were cervical disc displacement with radiculopathy, cervical radiculopathy, cervical spine sprain/strain, lumbar disc displacement with radiculopathy, lumbar radiculopathy, lumbar spine sprain/strain, thoracic spine sprain/strain, shoulder derangement, shoulder rotator cuff syndrome, shoulder sprain/strain, insomnia, anxiety, and depression. The rationale was not submitted. The request for authorization was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

RENTAL FOR THERMA COOLING SYSTEM (HOT/COLD COMPRESSION) WITH WATER CIRCULATING WRAP THREE (3) TIMES A WEEK SIX (6) WEEKS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Continuous - flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Continuous -flow Cryotherapy.

Decision rationale: The request for rental of a therma cooling system (hot/cold compression) with water circulating wrap 3 times a week 6 weeks is not medically necessary. The injured worker did not have reports from physical therapy. It also was not noted that the injured worker was participating in a home-based exercise program. The Official Disability Guidelines states recommended as an option after surgery, but not for nonsurgical treatment. The available scientific literature is insufficient to document that the use of continuous flow cooling symptoms (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but

these may be worthwhile benefits) in the outpatient setting. There is limited information to support active versus passive cryotherapy units. The medical necessity for the use of a continuous flow cryotherapy unit was not reported. Therefore, the request is not medically necessary.

PURCHASE OF TENS UNIT PURCHASE WITH ONE YEAR SUPPLIES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG-TWC: Pain TENS (updated 01/07/14).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, page(s) 114-117 Page(s): 114-117.

Decision rationale: The request for purchase of TENS unit purchase with 1 year supplies is not medically necessary. There were no reports submitted from physical therapy. It was not noted that the injured worker is participating in a home-based exercise program. The California Medical Treatment Utilization Schedule for the purchase of a TENS unit states that it is not recommended as a primary treatment modality, but a 1 month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. The types of pain the injured worker must have documented are neuropathic pain, phantom limb pain, complex regional pain syndrome 2, spasticity, and multiple sclerosis. Medical Guidelines also state that although electrotherapeutic modalities are frequently used in the management of chronic low back pain, few studies were found to support their use. Most studies on TENS can be considered of relatively poor methodological quality. TENS does not appear to have an impact on perceived disability or long-term pain. High frequency TENS appears to be more effective on pain intensity when compared with low frequency, but this has to be confirmed in future comparative trials. It is also not known if adding TENS to an evidence-based intervention, such as exercise, improves even more outcomes, but studies assessing the interactions between exercise and TENS found no cumulative impact. The rationale for the purchase of a TENS unit was not reported. The medical necessity for the purchase of a TENS unit was not documented. Therefore, the request is not medically necessary.