

Case Number:	CM14-0045273		
Date Assigned:	06/27/2014	Date of Injury:	10/19/2012
Decision Date:	08/13/2014	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	04/01/2014

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 Family Medicine and is licensed to practice in North Carolina. 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 patient is a 48-year-old with a reported date of injury of 10/19/2012. The mechanism of injury was due to continuous trauma while performing duties of a janitor. The patient has the diagnoses of traumatic right shoulder impingement syndrome with bursitis and tendonitis, traumatic left shoulder impingement syndrome with bursitis and tendonitis, cervical spondylosis with intermittent radiculitis, right ulnar nerve neuritis, mild right carpal tunnel syndrome with neuritis, and musculoligamentous strain of the lumbar/sacral (L/S) spine with ruptured disc at L4-5 and L5-S1 with right leg radiculitis. Treatment modalities have included medication, massage, physical therapy, acupuncture, aquatic therapy and lumbar epidural injections. A progress note dated 02/13/2014 indicates the patient has sharp constant pain in the neck with radiation to the upper back, sharp constant pain in both shoulders that radiates to the neck, and sharp constant pain that is worse on the right in the lumbar spine. Physical exam showed tenderness to palpation over the paraspinal muscles of the low back with spasm, as well as loss of cervical lordosis with palpable tenderness over the paraspinal muscles of the cervical spine and the anterior shoulder, acromioclavicular joint and suprascapular muscles. Treatment plan consisted of trigger point injection, medication continuation, right shoulder arthroscopic examination, epidural injection in the L/S spine, EMG/NCV testing, and cocked-up splint and soft elbow brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Purchase of Motorized Cold Therapy Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 308-310. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines) Low Back (updated 02/13/14), Cold/heat packs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

Decision rationale: The ACOEM guidelines address cold therapy for neck and upper back complaints as follows: "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and the return of patients to activities of normal daily living." This patient has failed to have a positive response to cold therapy documented with functional restoration, and therefore the request is not medically necessary.

Retro Purchase of Lumbosacral Orthosis Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 298-301. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines), Low Back (updated 02/13/14), Lumbar Supports.

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

Decision rationale: According to ACOEM, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Since the use of the brace is not been designated as being for the relief of an acute phase of symptoms, the brace is not medically necessary or appropriate.

Retro Thermophore Heating Pad: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 308-310. Decision based on Non-MTUS Citation ODG(The Official Disability Guidelines) (updated 02/13/14) Cold/heat packs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

Decision rationale: The ACOEM addresses heat therapy for neck and upper back complaints as follows: "There is no high-grade, scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be

monitored closely. Emphasis should focus on functional restoration and return of patients to activities of normal daily living."This patient has failed to have a positive response to heat therapy documented with functional restoration, and therefore the request is not medically necessary.

Retro Purchase of IF unit with electrodes: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 298-301, Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 120. Decision based on Non-MTUS Citation ODG(The Official Disability Guidelines) Low Back (updated 02/13/14) Interferential Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrotherapy Page(s): 114-120.

Decision rationale: The California MTUS addresses Interferential Current Stimulation (ICS) in the chronic pain section as follows: Not recommended as an isolated intervention. 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. According to current US treatment coverage recommendations, Health plans have taken a variety of positions with respect to ICS. California Technology Assessment Forum concluded that the treatment does not meet their criteria for coverage. While not recommended as an isolated intervention, patient selection criteria have been identified for cases in which interferential stimulation is to be used anyway: pain is ineffectively controlled due to diminished effectiveness of medications; or, pain is ineffectively controlled with medications due to side effects; or, there is history of substance abuse; or, significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or, the patient is unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A jacket should not be certified until after the one-month trial, and then only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. The patient has had an ineffective trial of a one-month period of the treatment, and thus, per the guidelines, the treatment is not indicated for continued use. Purchase of an IF unit is not medically necessary.