

<b>Case Number:</b>	CM14-0052419		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	04/28/2013
<b>Decision Date:</b>	08/28/2014	<b>UR Denial Date:</b>	04/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2014

### 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:

The patient is a 52-year-old female who has submitted a claim for cervical spine sprain/strain, cervical herniated disc syndrome without myelopathy, right shoulder infraspinatus tear, supraspinatus tendinitis and acromioclavicular osteoarthritis, right hand sprain/strain with subchondral cyst, lumbar spine herniated disc syndrome without myelopathy, and bilateral knee chondromalacia with internal derangement associated with an industrial injury date of 04/28/2013. Medical records from 10/26/2013 to 05/31/2014 were reviewed and showed that patient complained of neck pain (grade not specified), right shoulder pain graded 7/10, right hand pain graded 6/10, dull low back pain graded 8/10 with no associated radiation, tingling, or numbness, bilateral knee pain, graded 8/10 on the right and 6/10 on the left. Physical examination of the cervical spine revealed tenderness over the paracervical and trapezius muscles, limited range of motion (ROM), no weakness and negative Spurling's test. Physical examination of the bilateral shoulders revealed tenderness over the sternoclavicular and acromioclavicular joints, supraspinatus and greater tuberosity bilaterally but more pronounced on the right side. Shoulder ROM was decreased bilaterally. Neer's, Hawkins, and Codman's tests were negative. Physical examination of the bilateral wrists & hands was unremarkable. Physical examination of the lumbar spine revealed paraspinal tenderness, limited active ROM, and negative Goldthwait, Kemp's, straight leg rise, crossed straight leg raise, and femoral stretch tests bilaterally. Physical examination of the knee joints revealed tenderness over the knee joints bilaterally, decreased manual muscle testing (MMT) (3/5 bilaterally), limited knee ROM, and positive grinding and compression tests bilaterally. Sensation to light touch and deep tendon reflexes of all extremities were intact. Magnetic resonance imaging (MRI) of the cervical spine dated 10/26/2013 revealed straightening of cervical lordosis and C5-6 and C6-7 disc bulging. MRI of the right shoulder dated 10/26/2013 revealed complete infraspinatus tear, supraspinatus

tendinitis, and acromioclavicular osteoarthritis. MRI of the right hand dated 10/26/2013 revealed subchondral cyst formation in the first and third metacarpal head. MRI of the right knee dated 10/26/2013 revealed focal bone marrow edema, chondromalacia patella, and possible posterior horn of the medial meniscus tear. MRI of the left knee dated 10/26/2013 revealed chondromalacia patella and possible posterior horn of the medial meniscus tear. X-rays of the right shoulder, right hand, and lumbar spine (date not available) were unremarkable (05/28/2014). Treatment to date has included physical therapy, modality therapy, arm sling, heat wrap, and oral and topical medications. Utilization review dated 04/07/2014 denied the request for aqua relief system purchase, aspen summit back brace purchase, cervical home exercise rehab kit purchase, and Solace Multi Stim Unit 5 month rental with supplies. However, the rationale for requests' denials was not made available.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Aqua Relief System Purchase: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back (updated 3/31/2014, Low Back, Knee & Leg.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Continuous-flow cryotherapy and Durable medical equipment.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) does not specifically address the topic on continuous-flow cryotherapy. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Knee and Leg Chapter, was used instead. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. In addition, ODG states that durable medical equipment (DME) is recommended if there is a medical need and if the device or system meets Medicare's definition of DME. DME should withstand repeated use. It should primarily and customarily be used to serve a medical purpose and is not useful to a person in the absence of illness or injury. The equipment should be appropriate for use in a patient's home. In this case, the request of Aqua Relief system was to be used for nonsurgical treatment which is not recommended by the guidelines. The request likewise failed to specify the body part to be treated. There was no discussion concerning the medical need for Aqua Relief system. Therefore, the request for Aqua Relief System Purchase is not medically necessary.

#### **Aspen Summit Back Brace Purchase: 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 (ODG) Low Back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar Supports.

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines (ODG) was used instead. ODG states that lumbar support such as back brace is not recommended for prevention of back pain. A systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. In this case, the patient complained of chronic back pain. However, back braces are not recommended for back pain prevention as stated in the guidelines. There was no discussion as to why variance from the guidelines is needed. Therefore, the request for Aspen Summit Back Brace Purchase is not medically necessary.

**Cervical Home Exercise Rehabilitation Kit Purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines 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) Shoulder Chapter, Home exercise kits; Knee & Leg Chapter, Exercise equipment and durable medical equipment.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines (ODG) was used instead. ODG Shoulder Chapter recommends home exercise kits where home exercise programs and active self-directed home physical therapy are recommended. The ODG Knee and Leg Chapter states that exercise equipment are considered not primarily medical in nature. It also states that durable medical equipment should be primarily and customarily used to serve a medical purpose. In this case, there was no documentation of active participation by the patient in independent HEP. Moreover, the exact content of the exercise kit was not described in the progress reports. It is unclear if the included equipment will be considered for medical treatment. The medical necessity has not been established at this time due to lack of information. Therefore, the request for Cervical Home Exercise Rehabilitation Kit Purchase is not medically necessary.

**Solace Multi Stim Unit 5 month rental with supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 116, 114, 121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit, Interferential Current Stimulation, Neuromuscular Electrical Stimulation Page(s): 114-116, 118-120, 121.

**Decision rationale:** A search of online resources showed that Multi-Stim unit is a combination of TENS, interferential unit, and neuromuscular stimulator. As stated on pages 118-120 in the California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment

guidelines, interferential current stimulation is not recommended as an isolated intervention but is an adjunct for recommended treatments including return to work, exercise, and medications. A one month trial should be done given that the patient's pain is ineffectively controlled by medications, a history of substance abuse, significant pain from post-operative conditions limiting treatment, or unresponsive to conservative measures. Page 114 discusses TENS as opposed to multiple other devices. It is not recommended as a primary treatment modality, but a trial may be considered if used with functional restoration program. Page 121 states that there are no intervention trials suggesting benefit from NMES for chronic pain; hence, it is not recommended unless following stroke. In this case, the patient has undergone previous unspecified modality treatment without documentation of functional outcome as well as treatment frequency and duration, which are all necessary to support the continuation of transcutaneous electrotherapy. There was no documentation of active participation by the patient in independent home exercise program. The guidelines clearly state that transcutaneous electrotherapy or interferential unit stimulation cannot be used as a solitary form of treatment. The request likewise failed to specify the body part to be treated. Therefore, the request for Solace Multi Stim Unit 5 month rental with supplies is not medically necessary.