

Case Number:	CM14-0178690		
Date Assigned:	11/03/2014	Date of Injury:	09/01/2014
Decision Date:	02/20/2015	UR Denial Date:	10/15/2014
Priority:	Standard	Application Received:	10/28/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabn

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 patient is a 41-year-old female with a date of injury of 09/01/2014. According to Doctor's First Report dated 10/01/2014, the patient sustained injuries from a fall and burn when he came into contact with a hot pipe. The patient reports continued back pain with numbness and tingling in the left wrist. The patient notes that the burn does not hurt. Physical examination revealed decreased range of motion of the lumbar spine and negative straight leg raise. There was tenderness noted in the bilateral shoulders. There was decreased strength in the upper extremity and decreased sensation in the right anterolateral shoulder. Treatment plan included cyclobenzaprine, Motrin, UDS, hot and cold therapy unit, and physical therapy. Physical therapy initial evaluation report dated 10/16/2014 notes that the patient has cervical spine sprain/strain and left shoulder sprain/strain. The patient reported pain as 8/10 to 9/10 on a pain scale. Recommendation was made for 2 times a week treatment for the next 6 weeks. The current request is for IF unit, cold/hot unit purchase and a lumbosacral brace purchase. The utilization review denied the request on 10/15/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF unit (Interferential Unit): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 301, Chronic Pain Treatment Guidelines Interferential current stimulation (ICS) Page(s): 118.

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

Decision rationale: Based on the utilization review denial letter, the patient presents with cervical spine pain, thoracic spine pain, lumbar spine pain, shoulder pain, and wrist pain. The request is for an interferential unit. The report with the request was not provided. For interferential current stimulation (ICS), MTUS guidelines, pages 118 - 120, state that "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." These devices are recommended in cases where (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or (4) Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (5) Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). The reason for the request was not provided. There is no documentation of patient's history of substance abuse, operative condition, nor unresponsiveness to conservative measures. Documentation to support these criteria has not been met. Furthermore, MTUS requires a 30-day trial of the unit showing pain and functional benefit before a home unit is allowed. In this case, there was no 30-day trial with the interferential unit. Therefore, the requested IF unit is not medically necessary.

Hot/cold unit purchase for the cervical, thoracic, lumbar and bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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 under continuous flow cryotherapy.

Decision rationale: According to utilization review denial letter, the patient complains of having cervical spine pain, thoracic spine pain, lumbar spine pain, shoulder pain, and wrist pain. The request is for a hot/cold unit purchase for the cervical, thoracic, lumbar, and bilateral shoulders. The MTUS and ACOEM Guidelines do not discuss water therapy units. ODG Guidelines Pain Chapter under continuous flow cryotherapy states, "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In a postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated." The treater does not provide a reason for the request. There is no indication that the patient has undergone surgery or pending any surgery. In this case, ODG Guidelines do not support this type of device other than for postoperative recovery, and there is no indication that the patient has been authorized for

surgery. The requested hot/cold unit purchase for the cervical, thoracic, lumbar, and bilateral shoulders is not medically necessary.

Lumbosacral brace purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter, Lumbar Supports

Decision rationale: This patient presents with neck, low back, and bilateral shoulder pain. The current request is for lumbosacral brace purchase. The treating physician provides no rationale regarding this request. ACOEM Guidelines page 301 on lumbar bracing states, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines under its low back chapter (Lumbar Supports) state, "Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain." Under treatment, ODG further states, "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)." In this case, the patient does not present with fracture, documented instability, or spondylolisthesis to warrant lumbar bracing. For non-specific low back pain, there is very low quality evidence. The requested lumbosacral brace is not medically necessary.