

Case Number:	CM14-0200555		
Date Assigned:	12/19/2014	Date of Injury:	11/05/2004
Decision Date:	01/29/2015	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	12/01/2014

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 Physical Medicine Rehab, has a subspecialty in Interventional spine 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 45 year old female with an injury date on 11/05/2004. Based on the 09/22/2014 progress report provided by the treating physician, the diagnoses are:1. Left shoulder impingement with rotator cuff pathology2. Impending adhesive capsulitis, left shoulder3. Right knee pain, rule out internal derangement4. Low back pain with lower extremity symptoms5. Reactive depressionAccording to this report, the patient complains of 9/10 left shoulder pain, 6/10 right knee pain, and "5/10 low back pain with bilateral lower extremity symptoms." Physical exam reveals diffuse tenderness at the left shoulder with limited range of motion. Impingement test and Jobe test are positive. Spasm of the cervical trapezius muscles is noted. The 07/16/2014 report indicates the patient has "diffuse tenderness and full range of motion" of the lumbar spine.The treatment plan is to request for left shoulder arthroscopy/rotator cuff repair, cortisone injection for the left shoulder, MRI of the right knee, LSO brace, TENS unit , refill medications and return for a follow up visit in 6 weeks. The patient's condition is "Temporarily Totally Disabled for 6 weeks." There were no other significant findings noted on this report. The utilization review denied the request for LSO back brace and 1 TENS unit with supplies on 10/28/2014 based on the MTUS/ODG guidelines. The requesting physician provided treatment reports from 03/10/2014 to 09/22/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 LSO back brace (Retrospective prescribed on 09/22/2014): 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: According to the 09/22/2014 report, this patient presents with "5/10 low back pain with bilateral lower extremity symptoms." Per this report, the current request is for 1 LSO back brace (Retrospective prescribed on 09/22/2014) "to provide stability." The 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 regarding lumbar supports states "not recommended for prevention", however, "recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific lower back pain (very low quality evidence but may be a conservative option)." In this case, the patient does not present with fracture, instability or spondylolisthesis to warrant lumbar bracing. The guidelines support the use of a lumbar brace in the acute phase of care and this patient is in the chronic phase of care. Therefore, the current request is not medically necessary.

1 TENS unit with supplies (Retrospective prescribed on 09/22/2014): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

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

Decision rationale: According to the 09/22/2014 report, this patient presents with 9/10 left shoulder pain, 6/10 right knee pain, and 5/10 low back pain with bilateral lower extremity symptoms. Per this report, the current request is for 1 TENS unit with supplies (Retrospective prescribed on 09/22/2014). The treating physician states that the patient "recalls TENS was efficacious previously at physical therapy facilitating improved range of motion and diminution medication consumption." Regarding TENS units, the MTUS guidelines state "not recommended as a primary treatment modality, but a one-month home-based unit trial may be considered as a noninvasive conservative option" and may be appropriate for neuropathic pain. The guidelines further state a "rental would be preferred over purchase during this trial." Review of the medical records from 03/10/2014 to 09/22/2014 shows no indication that the patient has trialed a one-month rental to determine whether or not a TENS unit will be beneficial. The current request does not indicate if this request is for a one month trial or for purchase. Furthermore, MTUS supports TENS for the treatment of Neuropathic pain which has not been diagnosed. Therefore, the current request is not medically necessary.