

<b>Case Number:</b>	CM14-0025649		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	06/17/2011
<b>Decision Date:</b>	03/19/2015	<b>UR Denial Date:</b>	02/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/28/2014

### 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 & Rehabilitation

### 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 51 year old female, who sustained an industrial injury on 6/17/11. The injured worker has complaints of neck pain and stiffness and bilateral shoulder tightness with numbness and tingling. Treatment to date has included traction ; left trigger thumb release procedure; cortisone injection to her right carpal tunnel; ultrasound studies of the bilateral wrists with abnormalities; trigger point injections into her bilateral scapulae muscles; Magnetic Resonance Imaging (MRI) of her cervical spine; chiropractic and medications. According to the utilization review performed on 2/24/14, the requested 6 additional sessions of chiropractic therapy has been conditionally non-certified and the requested 1 theracane has been non-certified. The requested 1 theracane, the cited guidelines stat that it would not be advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. The guidelines state, massage devices are not recommended. The documentation noted that for chiropractic visits they need additional information; state the total number of physical therapy and or chiropractor visits completed over the past 6 months and submit quantified subjective, objective and functional improvement pre- and post-treatment with the said completed visits.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 THERACANE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Thera Cane is a self massage device used to decrease pain from tender, sore muscles. Guidelines are silent on this product and its treatment effectiveness. There is no evidence based studies on this DME product. In order to continue the treatment, the provider should identify clear objective documentation of functional improvement in the specific patient's condition as a result of the treatment provided. Documentation of functional improvement may be a clinically significant improvement in activities of daily living, a reduction in work restrictions, and a reduction in the dependency on continued medical treatment. Absent the above described documentation, there is no indication that the TheraCane which has been prescribed is effective or medically necessary for this patient. The 1 THERACANE is not medically necessary and appropriate.