

<b>Case Number:</b>	CM15-0107346		
<b>Date Assigned:</b>	06/11/2015	<b>Date of Injury:</b>	04/29/2010
<b>Decision Date:</b>	09/29/2015	<b>UR Denial Date:</b>	06/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/03/2015

### 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: Preventive Medicine, Occupational Medicine

### 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 (IW) is a 50 year old female who sustained an industrial injury on 04/29/2010. She reported shoulder, neck and back pain. The injured worker was diagnosed as having cervical spine strain/sprain; cervical spine discogenic disease (per MRI 07/01/10); status post cervical discectomy and fusion (02/01/11); lumbar spine strain/sprain, lumbar spine discogenic disease (MRI dated 07/02/2010); bilateral shoulder strain/sprain; left shoulder tendinitis, partial rotator cuff tear, impingement (MRI dated 03/28/2012); sleep disturbance secondary to pain; and depression, situational. Treatment to date has included physical therapy for the cervical spine and bilateral shoulders, diagnostic testing, medications of Norco, Cyclobenzaprine, and Tramadol. Currently, the injured worker complains of moderate pain in the neck, lower back, and bilateral shoulders. On examination there is tenderness to palpation and palpable spasm of the paraspinal muscles of the cervical and lumbar spine. The shoulders have tenderness to palpation. The treatment plan includes physical therapy, medications for pain, heat and cold unit with pump for cervical spine, lumbar spine, and bilateral shoulders, an uplift seat, prime interferential therapy, and urine toxicology testing. The IW is to return to modified work on 05/07/2015. Requests for authorization are made for the following items: 1. Home and cold unit with pump; 2. Prime interferential therapy (IF 4000); 3. Power uplift seat; 4. Physical therapy; twelve (12) sessions (2x6), cervical spine, lumbar and bilateral shoulders; 5. Tylenol # 3, #120 every 6 hours as needed; 6. Tramadol 50 mg #60 every 6 hours for pain; 7. Motrin (Ibuprofen) 800 mg #90, one tab by mouth three times daily with food as needed for pain; and 8. Urine toxicology.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Home and cold unit with pump:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 155.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Cold packs.

**Decision rationale:** The ODG cites no evidence that rotating heat and cold to the lumbar is effective in treating chronic lumbar pain. Insufficient testing exists to determine the effectiveness (if any) of heat/cold applications in treating mechanical neck disorders, though due to the relative ease and lack of adverse effects, local applications of cold packs may be applied during first few days of symptoms followed by applications of heat packs to suit patient. Home and cold unit with pump is not medically necessary.

**Prime interferential therapy (IF 4000):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Interferential current stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

**Decision rationale:** According to the MTUS an interferential current stimulation (ICS) is 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. A TENS unit without interferential current stimulation is the recommended treatment by the MTUS. Prime interferential therapy (IF 4000) is not medically necessary.

**Power uplift seat:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross Clinical UM Guideline, Durable Medical Equipment, Guideline #: CG-DME-10, Last Review Date: 02/13/2014.

**Decision rationale:** According to the Blue Cross Clinical UM Guideline for Durable Medical Equipment, durable medical equipment is considered medically necessary when all of a number of criteria are met including:- There is a clinical assessment and associated rationale for the requested DME in the home setting, as evaluated by a physician, licensed physical therapist, occupational therapist, or nurse; and- There is documentation substantiating that the DME is clinically appropriate, in terms of type, quantity, frequency, extent, site and duration and is considered effective for the individual's illness, injury or disease; and- The documentation supports that the requested DME will restore or facilitate participation in the individual's usual IADL's and life roles. The information should include the individual's diagnosis and other pertinent functional information including, but not limited to, duration of the individual's condition, clinical course (static, progressively worsening, or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The medical record does not contain sufficient documentation or address the above criteria. Power uplift seat is not medically necessary.

**Physical therapy; twelve (12) sessions (2x6), cervical spine, lumbar and bilateral shoulders:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine, Physical medicine guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** The MTUS allows for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Prior to full authorization, therapeutic physical therapy is authorized for trial of 6 visits over 2 weeks, with evidence of objective functional improvement prior to authorizing more treatments. There is no documentation of objective functional improvement. It is not clear if this is a request for initial or additional (where physical therapy treatments provided to date may have already exceeded guidelines regarding frequency) physical therapy treatments. Physical therapy; twelve (12) sessions (2x6), cervical spine, lumbar and bilateral shoulders is not medically necessary.

**Tylenol no. 3, #120 Q6HRN PRN:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 35.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that codeine is recommended as an option for mild to moderate pain. Codeine is a schedule C-II controlled substance. It is similar to morphine. 60 mg of codeine is similar in potency to 600 mg of acetaminophen. It is widely used as a cough suppressant. It is used as a single agent or in combination with acetaminophen (Tylenol with Codeine) and other products for treatment of

mild to moderate pain. There is no documentation supporting any functional improvement with the continued long-term use of Tylenol no. 3. Tylenol no. 3, #120 is not medically necessary.

**Tramadol 50mg #60 Q6H for pain:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Despite the long-term use of tramadol, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. Tramadol 50mg #60 is not medically necessary.

**Motrin (Ibuprofen) 800mg #90, one tab PO TID with food PRN for pain:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-73.

**Decision rationale:** The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. The medical record contains no documentation of functional improvement. Motrin (Ibuprofen) 800mg #90 is not medically necessary.