

Case Number:	CM15-0182736		
Date Assigned:	09/23/2015	Date of Injury:	05/15/2015
Decision Date:	11/06/2015	UR Denial Date:	08/17/2015
Priority:	Standard	Application Received:	09/17/2015

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: 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 57 year old female who sustained an industrial injury on 5-15-15. Diagnoses include lumbosacral musculoligamentous strain-sprain with radiculitis; rule out lumbosacral spine discogenic disease; bilateral shoulder strain-sprain; bilateral shoulder tendinitis; bilateral wrist strain-sprain; rule out bilateral wrist carpal tunnel syndrome; bilateral wrist tenosynovitis; bilateral ankle sprain-strain; bilateral foot sprain-strain; rule out bilateral foot plantar fasciitis. She currently complains of pain in the lower back with a pain level of 7 out of 10 and this was unchanged since previous visit; bilateral shoulders with right shoulder pain level of 6 out of 10 and left 8 out of 10; left thumb with a pain level of 8 out of 10; bilateral ankles, feet with an increase in pain bilaterally from 4 out of 10 on the right to 6 out of 10 and from 4 out of 10 on the left to 7 out of 10; pain of bilateral wrists with a pain level of 6 out of 10 for the right wrist. On physical exam of the lumbar spine there was tenderness to palpation and muscle spasms, restricted range of motion, positive straight leg raise bilaterally and trigger points noted; tenderness to palpation of bilateral shoulders with positive impingement and Supraspinatus tests; tenderness to palpation of the left hand; tenderness to palpation of bilateral ankles and feet. Diagnostics included x-ray of the left shoulder (6-4-15) showing calcification of humerus. Treatments to date include physical therapy with benefit; medications. The request for authorization dated 6-2-15 was for interferential unit; electrodes, batteries, set up and delivery; lumbar sacral orthosis back brace. On 8-17-15 Utilization Review evaluated and non-certified the requests for interferential unit; electrodes, batteries, set up and delivery of interferential unit based on undocumented failure of a transcutaneous electrical nerve stimulator unit, no

documentation that pain has not been effectively controlled due to decrease benefit of medications or that medications have not been ineffective; lumbar sacral orthosis back support based on guidelines not supporting its use for chronic low back pain without demonstration of spondylolisthesis, documented instability or post-operative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF (interferential) unit (infinite use): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The current request is for IF (Interferential) unit (infinite use). The RFA is dated 06/02/15. Treatment history includes medications, physical therapy, TENS, Functional capacity evaluation, and modified work. The patient remains off work. MTUS Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy section, pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.) If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. Per report 06/02/15, the patient presents with lower back, bilateral ankle and bilateral upper extremities pain. On physical examination of the lumbar spine there was tenderness to palpation, muscle spasms, restricted range of motion, positive straight leg raise bilaterally and trigger points noted. Examination of the upper extremities revealed tenderness to palpation of bilateral shoulders with positive impingement and Supraspinatus tests, and tenderness to palpation of the left hand. The treater does not discuss the requested IF unit. In regard to the infinite use of the IF unit, evidence of a successful 30 day trial has not been provided. The IF unit without first demonstrating efficacy with a 30 day trial does not meet MTUS guidelines. In addition, there is no evidence that pain is not effectively controlled due to the effectiveness of medication, substance abuse, pain due to postoperative conditions or unresponsiveness to conservative measures. Therefore, the request is not medically necessary.

Electrodes, batteries, set-up and delivery for IF unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The current request is for electrodes, batteries, set-up and delivery for if unit. The RFA is dated 06/02/15. Treatment history includes medications, physical therapy, TENS, Functional capacity evaluation, and modified work. The patient remains off work. MTUS Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy section, pages 118- 120, under Interferential Current Stimulation has the following regarding ICS units: "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.) If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. Per report 06/02/15, the patient presents with lower back, bilateral ankle and bilateral upper extremities pain. On physical examination of the lumbar spine there was tenderness to palpation, muscle spasms, restricted range of motion, positive straight leg raise bilaterally and trigger points noted. Examination of the upper extremities revealed tenderness to palpation of bilateral shoulders with positive impingement and Supraspinatus tests, and tenderness to palpation of the left hand. The treater does not discuss the requested IF unit, and supplies. In regard to the infinite use of the IF unit and supplies, evidence of a successful 30 day trial has not been provided. The IF unit without first demonstrating efficacy with a 30 day trial does not meet MTUS guidelines. In addition, there is no evidence that pain is not effectively controlled due to the effectiveness of medication, substance abuse, pain due to postoperative conditions or unresponsiveness to conservative measures. The patient does not meet the indications for the use of an IF unit, and therefore the requested supplies to be used in conjunction with the unit is not medically necessary.

Lumbar sacral orthosis (LSO) back support: 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), Low Back - Supports.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter under Lumbar Supports.

Decision rationale: The current request is for lumbar sacral orthosis (LSO) back support. The RFA is dated 06/02/15. Treatment history includes medications, physical therapy, TENS, Functional capacity evaluation, and modified work. The patient remains off work. MTUS/ACOEM Guidelines, Low Back complaints, Chapter 12, page 301 on lumbar

bracing states: Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Official Disability Guidelines, Low Back chapter under Lumbar Supports states: Not recommended for prevention; however, recommended as an option for compression fracture and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain, very low quality evidence, but may be a conservative option. Per report 06/02/15, the patient presents with lower back, bilateral ankle and bilateral upper extremities pain. On physical examination of the lumbar spine there was tenderness to palpation, muscle spasms, restricted range of motion, positive straight leg raise bilaterally and trigger points noted. Examination of the upper extremities revealed tenderness to palpation of bilateral shoulders with positive impingement and Supraspinatus tests, and tenderness to palpation of the left hand. Treatment plan included a lumbar orthosis back support. While ODG guidelines indicate that such lumbar bracing may be a conservative option for nonspecific low back pain, there is very low-grade evidence for this treatment modality. This patient presents with chronic lower back pain without a history of surgical intervention, and there is no indication that this patient has any lumbar instability, spondylosis, fractures which would warrant lumbar bracing. Therefore, the request is not medically necessary.