

<b>Case Number:</b>	CM15-0219592		
<b>Date Assigned:</b>	11/12/2015	<b>Date of Injury:</b>	07/13/2015
<b>Decision Date:</b>	12/31/2015	<b>UR Denial Date:</b>	10/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/09/2015

### 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 54-year-old female who sustained an industrial injury on 7-13-15. A review of the medical records indicates she is undergoing treatment for cervical spine musculoligamentous sprain and strain with multilevel disc protrusions, stenosis, and moderate degenerative disc disease with right upper extremity radiculitis, right shoulder periscapular strain, thoracic spine musculoligamentous sprain and strain, and lumbar spine musculoligamentous sprain and strain with bilateral sacroiliac joint sprain. Medical records (7-29-15, 8-4-15, and 9-1-15) indicate ongoing complaints of neck pain. She rated her pain "10 out of 10" on 7-29-15 and indicated it to be "extremely severe". The 9-1-15 record indicates complaints of neck pain radiating to the right upper extremity, upper back pain, right shoulder pain, low back pain, and headaches. The physical exam (9-1-15) reveals tenderness on palpation over the periscapular region and posterior musculature of the right shoulder. Range of motion is noted to be diminished. The cervical spine exam reveals a decrease in the cervical lordotic curvature. Tenderness to palpation with "moderate" spasm and guarding is noted over the paraspinal musculature and upper trapezius muscles bilaterally. Axial compression test is positive with radiating symptoms to the right upper extremity. Spurling's maneuver is positive on the right. Range of motion is noted to be diminished. Tenderness to palpation with muscle spasm and guarding is present over the paraspinal musculature and mid trapezius muscle on the right during the thoracic exam. A trigger point is noted on the right rhomboid musculature. Range of motion is noted to be decreased. The lumbar spine reveals tenderness to palpation over the paraspinal musculature and sacroiliac joints bilaterally. The straight leg raise is negative

bilaterally. Sacroiliac stress test is positive. Range of motions is diminished. Sensation is noted to be decreased in the right upper extremity. Sensation in the left upper extremity and lower extremities is "intact". Motor testing is "4 out of 5" due to pain in the right upper extremity. Diagnostic studies have included x-rays of the cervical spine and an MRI of the cervical spine. Treatment has included medications. She was evaluated by physical therapy, but no sessions were attended. She is not working. Treatment recommendations include acupuncture, a home interferential unit, a Vista cervical collar, Thermophore heating pad, a pain management consultation, and an EMG-NCV study. The utilization review (10-23-15) includes requests for authorization of a home interferential unit, a Vista cervical collar, and a Thermophore heating pad. All requests were denied.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Home Interferential Unit:** Upheld

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

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

**Decision rationale:** The patient was injured on 07/13/15 and presents with pain in her neck, low back, right shoulder, and thoracic spine. The request is for a home interferential unit. The patient is diagnosed with cervical spine musculoligamentous sprain and strain with multilevel disc protrusions, stenosis, and moderate degenerative disc disease with right upper extremity radiculitis, right shoulder periscapular strain, thoracic spine musculoligamentous sprain and strain, and lumbar spine musculoligamentous sprain and strain with bilateral sacroiliac joint sprain. The RFA is dated 09/01/15 and the patient has light work duty. MTUS Guidelines, Interferential Current Stimulation (ICS), 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 is not provided. Review of progress reports does not show documentation of patient's history of substance abuse, operative condition, nor unresponsiveness to conservative measures. Documentation to support MTUS 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 and the request is for a home IF unit. Therefore, the requested IF stimulator is not medically necessary.

**Thermophore Heating Pad: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, under heat therapy.

**Decision rationale:** The patient was injured on 07/13/15 and presents with pain in her neck, low back, right shoulder, and thoracic spine. The request is for a thermophore heating pad. The utilization review denial rationale is that "there is no indication that one needs specific equipment to provide heat as therapy." The patient is diagnosed with cervical spine musculoligamentous sprain and strain with multilevel disc protrusions, stenosis, and moderate degenerative disc disease with right upper extremity radiculitis, right shoulder periscapular strain, thoracic spine musculoligamentous sprain and strain, and lumbar spine musculoligamentous sprain and strain with bilateral sacroiliac joint sprain. The RFA is dated 09/01/15 and the patient has light work duty. ODG Guidelines, Low Back Chapter, under heat therapy states the following: "Recommended as an option. A number of studies show continuous low-level heat wrap therapy to be effective for treating low back pain." ODG further states, "Active warming reduces acute low back pain during rescue transport. Combining continuous low-level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared with either intervention alone or control." ODG also supports heat as a method of pain reduction for knee complaints, also. The reason for the request is not provided. It does not appear that the patient has used this heating pad prior to this request. ODG guidelines recommend the use of heat therapy for acute low back pain, which this patient presents with. Therefore, the request is medically necessary.

**Vista Cervical Collar: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, and Shoulder Complaints 2004, Section(s): Initial Care.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care.

**Decision rationale:** The patient was injured on 07/13/15 and presents with pain in her neck, low back, right shoulder, and thoracic spine. The request is for a vista cervical collar. The patient is diagnosed with cervical spine musculoligamentous sprain and strain with multilevel disc protrusions, stenosis, and moderate degenerative disc disease with right upper extremity radiculitis, right shoulder periscapular strain, thoracic spine musculoligamentous sprain and strain, and lumbar spine musculoligamentous sprain and strain with bilateral sacroiliac joint sprain. The RFA is dated 09/01/15 and the patient has light work duty. MTUS/ACOEM Guidelines Chapter 8, under Initial Care Section, page 175 states "Cervical collars: Initial care other miscellaneous therapies have been evaluated and found to be ineffective or minimally effective. For example, cervical collars have not been shown to have any lasting benefit, except for comfort in the first few days of clinical course in severe cases; in fact, weakness may result

from prolonged use and will contribute to debilitation. Immobilization using collars in prolonged periods of rest are generally less effective than having patients maintain their usual, 'pre-injury' activities." Regarding cervical collars, the ODG Guidelines under its neck and upper back chapters states, "Maybe appropriate where post-operative and fracture indications exist." The reason for the request is not provided. MTUS/ACOEM guidelines do not support cervical collars and ODG states it may be appropriate for post-operative use or when there is a fracture. In this case, the patient is not in a post-operative state and there is no documented concern for fracture. This request is not in accordance with guidelines. Therefore, the request is not medically necessary.