

<b>Case Number:</b>	CM15-0040615		
<b>Date Assigned:</b>	03/10/2015	<b>Date of Injury:</b>	08/02/2013
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	02/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2015

### 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: 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 male who reported an injury on 08/02/2013. The mechanism of injury was the injured worker was going from the steps of the cab to the bed of a crane and was hanging onto the air horn. The injured worker stepped with his right foot onto the bed of the crane, and when he stepped with his left foot, his right foot slipped, causing him to fall until his arm caught him. The documentation of 02/03/2015 revealed the injured worker had complaints of back pain and neck pain. The injured worker was noted to undergo deep tissue massage, chiropractic care, electrical stimulation, and Tiger balm. The injured worker had physical therapy and acupuncture, as well as an injection. Prior studies included x-rays and MRIs. The surgical history was noted to include a shoulder surgery. The physical examination of the cervical spine revealed decreased range of motion and tenderness to palpation over the bilateral scalenes, trapezius, and teres major. There was a positive Adson's bilaterally. The injured worker had decreased range of motion of the thoracolumbar spine. The injured worker had upper extremity reflexes within normal limits. The injured worker had decreased sensation at C5, C6, C7, and C8 bilaterally. Sensation of the lower extremities and strength were within normal limits. The recommendation included aquatic physical therapy and strengthening for range of motion, x-rays of the cervical spine and lumbar spine, an IF unit for treatment of muscle spasms, a lumbar corset for lumbar spine support, a lumbar traction kit to improve activities of daily living and function, and a home exercise kit for strengthening and range of motion as well as a cervical collar. Additionally, medications included cyclobenzaprine, Ketoprofen/menthol /capsaicin cream, and lidocaine/hyaluronic acid patches. The diagnoses included noncongenital

thoracic outlet syndrome, lumbago, and cervical spine HNP. There was no Request for Authorization submitted to support the request.

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

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

#### **Interferential Unit with 2 monthly supplies: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines do not recommend interferential current stimulation (ICS) as an isolated intervention and should be used with recommended treatments including work, and exercise. The clinical documentation submitted for review failed to provide documentation that the injured worker would be exercising. The request as submitted failed to indicate the specific supplies being requested. There was a lack of documentation indicating whether the unit was for rental or purchase and documentation of exceptional factors. The request as submitted failed to indicate the body part to be treated. Given the above, the request for an interferential unit with 2-month lead supplies is not medically necessary.

#### **Cervical Collar: 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): 173.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicates that immobilization using collars and prolonged periods of rest are less effective than having injured workers maintain their usual preinjury activities. There was a lack of documentation of exceptional factors to support non-adherence to guideline recommendations. Given the above, the request for a cervical collar is not medically necessary.

#### **Home Exercise Kit: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Home Exercise Kits.

**Decision rationale:** The Official Disability Guidelines recommend exercise kits as an option. There was a lack of documentation indicating the components for the exercise kit. Additionally, the request as submitted failed to indicate the body part to be treated with the home exercise kit. Given the above, and the lack of documentation, the request for a home exercise kit is not medically necessary.

**Lumbar Traction:** Upheld

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

**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, Traction.

**Decision rationale:** The Official Disability Guidelines indicate a home based controlled gravity traction unit may be appropriate as a noninvasive conservative option if it is used as an adjunct to a program of evidence based conservative care to achieve functional restoration. It has not been proven effective for lasting relief in the treatment of low back pain. The clinical documentation submitted for review indicated the request was made to improve the injured worker's activities of daily living and function. There was a lack of documentation indicating the injured worker would utilize the unit as an adjunct. The request as submitted failed to indicate the specific type of unit being requested and whether the unit was for rental or purchase. Given the above, the request for lumbar traction is not medically necessary.

**LSO Brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** The American College of Occupational and Environmental Medicine Guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Additionally, continued use of back braces could lead to deconditioning of the spinal muscles. The clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for an LSO brace is not medically necessary.