

Case Number:	CM15-0052559		
Date Assigned:	03/26/2015	Date of Injury:	12/31/2013
Decision Date:	05/01/2015	UR Denial Date:	03/03/2015
Priority:	Standard	Application Received:	03/19/2015

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 is a 37-year-old male who sustained a work related injury December 31, 2013. According to a primary treating physician's report, dated February 19, 2015, the injured worker presented with continued complaints of neck pain radiating to the right upper extremities with tingling shooting down to the right shoulder and elbow. The neck pain worsens with hyperextension. He has also noted a headache, averaging three times a week, which starts when moving his head up without nausea, vomiting, or photophobia. He has been taking over the counter aspirin with relief. Diagnoses included cervical sprain/strain, neck; post-concussion syndrome; cervical degenerative disc disease, cervical radiculitis; hypertension. Treatment plan included TENS trial, cervical MRI, continued medication, topical cream, and follow-up with family practice physician for hypertension.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flex/Ext X-ray of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Chapter, Radiography (x-rays).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

Decision rationale: According to MTUS guidelines, "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly provided any red-flag conditions are ruled out." X-rays imaging is recommended in neck and upper back complaints in case of suspicion of fracture, neurological deficit related to tumor, trauma and infection. There is no clear evidence that the patient developed new symptoms or have red flags pointing toward cervical spine damage. The patient has undergone an MRI of the cervical spine and an electrodiagnostic testing, performed on October 16, 2014, and there is no indication of change or deterioration in the patient's condition. Therefore, the prescription of Flex/Ext X-ray of the cervical spine is not medically necessary.

TENS (transcutaneous electrical nerve stimulation) unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous Electrical Nerve Stimulation Page(s): 97.

Decision rationale: According to MUTUS guidelines, TENS is not recommended as primary treatment modality, but a one month based trial may be considered, if used as an adjunct to a functional restoration program. There is no evidence that a functional restoration program is planned for this patient. Furthermore, there is no clear information about a positive one-month trial of TENS. There is no recent documentation of recent flare of the patient's pain. The provider should document how TENS will improve the functional status and the patient's pain condition. Therefore, the prescription of TENS unit is not medically necessary.

TheraCane: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation website, <http://www.theracane.com/contactUs.html>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Walking aids (canes, crutches, braces, orthoses, & walkers). <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, Walking aids "Recommended, as indicated below. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. (Van der Esch, 2003) There is evidence that a brace has additional beneficial effect for knee osteoarthritis compared with medical treatment alone, a laterally wedged insole (orthosis) decreases NSAID intake compared with a neutral insole, patient compliance is better in the laterally wedged insole compared with a neutral insole, and a strapped insole has more adverse effects than a lateral wedge insole. (Brouwer-Cochrane, 2005) Contralateral cane placement is the most efficacious for persons with knee osteoarthritis. In fact, no cane use may be preferable to ipsilateral cane usage as the latter

resulted in the highest knee moments of force, a situation that may exacerbate pain and deformity. (Chan, 2005) While recommended for therapeutic use, braces are not necessarily recommended for prevention of injury. (Yang, 2005) Bracing after anterior cruciate ligament reconstruction is expensive and is not proven to prevent injuries or influence outcomes. (McDevitt, 2004) Recommended, as indicated below. Assistive devices for ambulation can reduce pain associated with OA. Frames or wheeled walkers are preferable for patients with bilateral disease. (Zhang, 2008) While foot orthoses are superior to flat inserts for patellofemoral pain, they are similar to physical therapy and do not improve outcomes when added to physical therapy in the short-term management of patellofemoral pain. (Collins, 2008) In patients with OA, the use of a cane or walking stick in the hand contra lateral to the symptomatic knee reduces the peak knee adduction moment by 10%. Patients must be careful not to use their cane in the hand on the same side as the symptomatic leg, as this technique can actually increase the knee adduction moment. Using a cane in the hand contra lateral to the symptomatic knee might shift the body's center of mass towards the affected limb, thereby reducing the medially directed ground reaction force, in a similar way as that achieved with the lateral trunk lean strategy described above. Cane use, in conjunction with a slow walking speed, lowers the ground reaction force, and decreases the biomechanical load experienced by the lower limb. The use of a cane and walking slowly could be simple and effective intervention strategies for patients with OA. In a similar manner to which cane use unloads the limb, weight loss also, decreases load in the limb to a certain extent and should be considered as a long-term strategy, especially for overweight individuals. (Reeves, 2011) See also U-Step walker." There is no documentation that the patient developed balance and walking difficulties requiring a cane or another walking aid. Therefore, the request of a Theracane is not medically necessary.