

Case Number:	CM15-0078958		
Date Assigned:	07/30/2015	Date of Injury:	05/30/2013
Decision Date:	09/25/2015	UR Denial Date:	04/20/2015
Priority:	Standard	Application Received:	04/24/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 male who sustained an industrial lifting injury on 05/30/2013. The injured worker was diagnosed with lumbar spine sprain/strain, bilateral lumbosacral radicular pain and left thumb sprain/strain. No surgical interventions were documented. Treatment to date has included diagnostic testing with recent lumbar spine magnetic resonance imaging (MRI) in December 2014, anatomical impairment measurements, psychological evaluation, lumbar epidural steroid injection, physical therapy acupuncture therapy (7 sessions), chiropractic therapy (10 sessions) and medications. According to the primary treating physician's progress report on March 5, 2015, the injured worker continues to experience low back pain radiating into both lower extremities, right greater than left, associated with weakness, numbness and tingling. His low back pain also radiates up to the mid back and shoulder blades. The injured worker rates his pain level at 6 out of 10. The injured worker also reports left thumb pain rated as 3-6 out of 10 on the pain scale. Examination noted generalized stiffness with painful movements of the cervical spine. The mid back examination was normal. The examination of the lumbar spine noted midline tenderness from L2-S1 and bilateral lumbar facet tenderness at L4-L5 and L5-S1. There was mild sacroiliac and sciatic notch tenderness. Movement of the thoracic and lumbar spine remained painful. Straight leg raise and Lasegue's were positive bilaterally. The injured worker was unable to walk on his toes and heels and had a staggering gait. Sensory examination showed hypoalgesia in the distribution of the bilateral L4, L5 and S1 nerve roots. Motor strength was decreased in both lower extremities. Bilateral deep tendon reflexes of the lower extremities were documented at 1+ bilaterally. The examination of

the left thumb noted tenderness over the first carpometacarpal joint. Current medications are listed as Norco 10/325mg, Warfarin and topical analgesics. Treatment plan consists of continuing with conservative measures and the current request for a lumbosacral orthosis back support purchase, hot and cold therapy unit for purchase, hot and cold therapy unit wrap for purchase, Interferential Stimulator (IF) unit for 1month rental and Interferential Stimulator (IF) unit electrodes and batteries for 1 month supply.

IMR ISSUES, DECISIONS AND RATIONALES

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

LSO back support for purchase: 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, Lumbar supports.

Decision rationale: Per the ODG with regard to lumbar supports: Not recommended for prevention recommended as an option for treatment. See below for indications. Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. (Jellema-Cochrane, 2001) (Van Poppel, 1997) (Linton, 2001) (Assendelft-Cochrane, 2004) (Van Poppel, 2004) (Resnick, 2005) Lumbar supports do not prevent LBP. (Kinkade, 2007) A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. (Bigos, 2009) This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. (van Duijvenbode, 2008) Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). As there is only very low-quality evidence supporting the use of back braces for the purpose of treatment, the request is not medically necessary and cannot be affirmed.

Hot/cold therapy unit for purchase: 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, Continuous-flow cryotherapy.

Decision rationale: The MTUS is silent on the use of cold therapy units. The ODG states continuous-flow cryotherapy is "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting." As the ODG only supports the use of cold therapy units for up to 7 days, purchase is not medically necessary.

Hot/cold therapy unit pad/wrap for purchase: 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, Continuous-flow cryotherapy.

Decision rationale: The MTUS is silent on the use of cold therapy units. The ODG states continuous-flow cryotherapy is "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting." As the requested cold therapy unit was not medically necessary, pad/wrap is not medically necessary.

IF unit x 1 month rental: 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: Per MTUS CPMTG with regard to interferential current stimulation: "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." As the requested treatment is not recommended by the MTUS, and has only limited evidence of improvement when used in conjunction with other recommended treatments, the request is not medically necessary.

IF unit electrodes and batteries x 1 month supply: 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: Per MTUS CPMTG with regard to interferential current stimulation: "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." As the requested IF unit was not medically necessary, the request for electrodes and batteries is not medically necessary.

Set-up and delivery: 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: Per MTUS CPMTG with regard to interferential current stimulation: "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." As the requested IF unit was not medically necessary, the requested set up and delivery is not medically necessary.