

Case Number:	CM15-0087109		
Date Assigned:	05/11/2015	Date of Injury:	05/16/1985
Decision Date:	06/12/2015	UR Denial Date:	04/14/2015
Priority:	Standard	Application Received:	05/06/2015

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(n) 55 year old female, who sustained an industrial injury on 5/16/85. She reported pain in her neck and back. The injured worker was diagnosed as having cervical sprain and lumbar sprain. Treatment to date has included NSAIDs, Prilosec and a TENs units. As of the PR2 dated 3/25/15, the injured worker reports pain in her neck and back. Objective findings include cervical flexion and extension 70 degrees, deltoids and biceps are 5/5 and wrist flexors and extensors are 5/5. The treating physician requested an IF unit with three months supplies, an lumbar spine pillow and physical therapy 2 x weekly for 4 weeks on the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential (IF) unit with 3 months supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, pages 115-118.

Decision rationale: The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage, increased pain relief or improved functional status derived from any transcutaneous electrotherapy to warrant an interferential unit for home use for this chronic injury. Additionally, IF unit may be used in conjunction to a functional restoration process with improved functional status, decreased medical utilization and exercises not demonstrated here. The Interferential (IF) unit with 3 months supplies is not medically necessary and appropriate.

Lumbar spine pillow (1): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pillow, page 626 and Other Medical Treatment Guidelines Other Medical Treatment Guideline or Medical Evidence: Other Medical Treatment Guideline or Medical Evidence, From <http://www.aetna.com/cpb/medical> Clinical Policy Bulletin: Pillows and Cushions, Number: 0456 Policy.

Decision rationale: Although MTUS, ACOEM Guidelines do not specifically address or have recommendations for this DME, other guidelines such as ODG and Aetna's contractual definition of durable medical equipment (DME) in that they are not durable and because they are not primarily medical in nature and not mainly used in the treatment of disease or injury. It further states "Cushions may be covered if it is an integral part of, or a medically necessary accessory to, covered DME" such as seat cushions for required wheelchairs in prevention of decubiti. Regarding sleeping pillows (ergonomic pillows, orthopedic pillows, orthopedic foam wedges) (e.g., Accu-Back Ergonomic Sleeping Pillow, Core Pillow, Mediflow Waterbase Pillow), a number of specialized pillows and cushions have been used for cushioning and positioning in the treatment of decubiti, burns, musculoskeletal injuries and other medical conditions. Aetna does not generally cover pillows and cushions, regardless of medical necessity, because they do not meet Aetna's definition of covered durable medical equipment, in that, pillows and cushions are not made to withstand prolonged use. In addition, most pillows and cushions are not primarily medical in nature, and are normally of use to persons who do not have a disease or injury. ODG states the cervical pillow may be appropriate in conjunction with daily exercise and should be treated by health professionals trained to teach both exercises and the appropriate use of a neck support pillow during sleep as either strategy alone did not give the desired clinical benefit. Submitted reports have not demonstrated support for this DME per above references. The Lumbar spine pillow (1) is not medically necessary and appropriate.

Physical therapy 2x4 weeks on the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy 2x4 weeks on the lumbar spine is not medically necessary and appropriate.