

<b>Case Number:</b>	CM15-0089639		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	07/02/2012
<b>Decision Date:</b>	07/02/2015	<b>UR Denial Date:</b>	04/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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 49 year old female, who sustained an industrial injury on July 2, 2012. She reported an injury to her neck, bilateral shoulders and low back. Treatment to date has included physical therapy, work restrictions and medication. Currently, the injured worker complains of frequent burning and aching pain of the neck with pain radiating to the bilateral shoulders. She reports frequent sharp bilateral shoulder pain and continuous sharp lower back pain. She rates her neck pain as a 4 on a 10-point scale, her bilateral shoulder pain a 4 on a 10-point scale and her low back pain a 6 on a 10-point scale. Her pain is aggravated by activity and relieved with rest. Her range of motion is decreased due to pain in her cervical spine, lumbar spine and shoulders. The Diagnoses associated with the request include cervicgia, lumbago, lumbar radiculitis/neuritis and bilateral shoulder impingement syndrome. The treatment plan includes MRI of the cervical spine, bilateral shoulders and lumbar spine, acupuncture for the cervical spine, shoulders and low back, muscle nerve stimulator unit, heat/cold pack, home exercise kits and work modifications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar exercise kit purchase:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints page(s): 309.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Exercise.

**Decision rationale:** Based on the 3/11/15 progress report provided by the treating physician, this patient presents with neck pain rated 4-10/10 radiating to bilateral shoulders, bilateral shoulder pain rated 4-10/10, and low back pain radiating to bilateral hips rated 6-10/10. The provider has asked for Lumbar Exercise Kit Purchase on 3/11/15. The request for authorization was not included in provided reports. The patient has not had any surgical interventions on the neck, shoulder, or back per review of reports. The patient's current medication is Ibuprofen per 3/11/15 report. The patient has had 3 months of prior physical therapy on the neck/shoulders/back which gave "temporary benefit," had chiropractic treatment, an unspecified back injection, multiple MRIs, and bracing per 3/11/15 report. The patient has had insomnia from Ultram per 10/22/14 report. The patient began a stretching program on 10/22/14 report. The patient's work status is temporarily totally disabled, and has not worked since September 2012. Official Disability Guidelines support home exercise kits for shoulder and knee conditions but does not discuss it for any other body parts. ACOEM Guidelines page 309 under low back chapter recommends, "Low stress aerobic exercise." ACOEM further states, "there is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise." Official Disability Guidelines, Low Back Chapter Exercise topic states that exercise is recommended for treatment and prevention. In this case, patient has a chronic pain condition of the back/neck/shoulders. The patient has failed conservative treatment, including 3 months of physical therapy with limited benefit. Official Disability Guidelines does provide some support for Home Exercise kits in the Shoulder and Knee and Leg chapters, and exercise is recommended by ODG and ACOEM for lower back pain. A home exercise kit may be quite helpful in aiding the patient with transitioning to a home exercise program. The request IS medically necessary.

**Heat/cold unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints page(s): 212.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Chapter, Continuous-Flow Cryotherapy, Low Back Chapter, Heat Therapy.

**Decision rationale:** Based on the 3/11/15 progress report provided by the treating physician, this patient presents with neck pain rated 4-10/10 radiating to bilateral shoulders, bilateral shoulder pain rated 4-10/10, and low back pain radiating to bilateral hips rated 6-10/10. The provider has asked for Heat/Cold Unit on 3/11/15. The requesting progress report dated 3/11/15 further specifies: "I am requesting authorization for heat or cold pack for cervical spine and lumbar spine." The request for authorization was not included in provided reports. The patient has not

had any surgical interventions on the neck, shoulder, or back per review of reports. The patient's current medication is Ibuprofen per 3/11/15 report. The patient has had 3 months of prior physical therapy on the neck/shoulders/back which gave temporary benefit, had chiropractic treatment, an unspecified back injection, multiple MRIs, and bracing per 3/11/15 report. The patient has had insomnia from Ultram per 10/22/14 report. The patient began a stretching program on 10/22/14 report. The patient's work status is temporarily totally disabled, and has not worked since September 2012. MTUS does not discuss Cold therapy, though Official Disability Guidelines, Knee and Leg Chapter, under Continuous-flow cryotherapy states the following regarding postoperative cold therapy units: "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 - eg, muscle strains and contusions - has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy are extremely rare but can be devastating." Official Disability Guidelines Back chapter for Heat therapy states: "recommended. 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. Heat therapy has been found to be helpful for pain reduction and return to normal function." The provider has request "hot or cold pack for cervical spine and lumbar spine." In regard to cold therapy, Official Disability Guidelines specifies a 7 day rental for post-operative use. However, the patient has no surgical interventions planned. The treating physician also does not indicate that the patient has an acute low back pain, for which use of heat modality may be indicated per Official Disability Guidelines. There is no discussion regarding a flare-up, new injury or an exacerbation. The request IS NOT medically necessary.

**Retro: DME Multi stim unit supplies 5 months rental cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines page(s): 121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit, Neuromuscular electrical stimulation (NMES) page(s): 116-121.

**Decision rationale:** Based on the 3/11/15 progress report provided by the treating physician, this patient presents with neck pain rated 4-10/10 radiating to bilateral shoulders, bilateral shoulder pain rated 4-10/10, and low back pain radiating to bilateral hips rated 6-10/10. The provider has asked for RETRO: DME Multi Stim Unit Supplies 5 Months Rental Cervical Spine on 3/11/15. The provider states in requesting progress report dated 3/11/15: "I am requesting authorization for durable medical equipment in the form of muscle stimulator unit for five months for cervical spine and lumbar spine." The request for authorization was not included in provided reports. The patient has not had any surgical interventions on the neck, shoulder, or back per review of reports. The patient's current medication is Ibuprofen per 3/11/15 report. The patient has had 3 months of prior physical therapy on the neck, back injection, multiple MRIs, and bracing per 3/11/15 report. The patient has had insomnia from Ultram per 10/22/14 report. The patient began a stretching program on 10/22/14 report. The patient's work status is temporarily totally

disabled, and has not worked since September 2012. For TENS unit, MTUS guidelines, on page 116, require (1) documentation of pain of at least three months duration (2) there is evidence that other appropriate pain modalities have been tried (including medication) and failed. (3) a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. (4) other ongoing pain treatment should also be documented during the trial period including medication usage (5) a treatment plan including the specific short- and long-term goals of treatment with the Tens unit should be submitted (6) a 2-lead unit is generally recommended; if a 4-lead unit is recommended, MTUS recommends TENS for neuropathic pain, CRPS, Multiple Sclerosis, Phantom pain, and spasticity pain. For Neuromuscular electrical stimulation (NMES), or EMS, MTUS page 121 states, "not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain." In review of the medical records provided, there is no evidence the patient has had prior use of a TENS unit. Five month of use would exceed the duration recommended by MTUS, as patient has not yet had a month-long trial. Furthermore, this unit is a combo with an EMS. MTUS does not support EMS, or NMES for chronic pain condition. The request IS NOT medically necessary.

**Purchase: Shoulder exercise rehab kit:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints page(s): 308.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, Exercise Kit.

**Decision rationale:** Based on the 3/11/15 progress report provided by the treating physician, this patient presents with neck pain rated 4-10/10 radiating to bilateral shoulders, bilateral shoulder pain rated 4-10/10, and low back pain radiating to bilateral hips rated 6-10/10. The provider has asked for Purchase: Shoulder Exercise Rehab Kit on 3/11/15. The request for authorization was not included in provided reports. The patient has not had any surgical interventions on the neck, shoulder, or back per review of reports. The patient's current medication is Ibuprofen per 3/11/15 report. The patient has had 3 months of prior physical therapy on the neck/shoulders/back which gave temporary benefit, had chiropractic treatment, an unspecified back injection, multiple MRIs, and bracing per 3/11/15 report. The patient has had insomnia from Ultram per 10/22/14 report. The patient began a stretching program on 10/22/14 report. The patient's work status is temporarily totally disabled, and has not worked since September 2012. Official Disability Guidelines shoulder chapter, exercise kit states the following: "See Exercises, where home exercise programs are recommended; & Physical therapy, where active self-directed home physical therapy is recommended. In this RCT a specific shoulder home exercise program resulted in 69% good outcomes versus 24% in the sham exercise group, and 20% of patients in the specific exercise group subsequently chose to undergo surgery versus 63% in the control group. Shoulder disorders may lead to joint stiffness

more often than other joint disorders. Therapeutic exercise, including strengthening, should start as soon as it can be done without aggravating symptoms." In this case, the patient has chronic bilateral shoulder pain, with continued deficits. The patient has not had prior usage of exercise kit for the shoulder per review of reports. The requested exercise kit is indicated per Official Disability Guidelines. The shoulder exercise rehab kit IS medically necessary.