MAXIMUS Federal Services

Case Number:	CM14-0123142		
Date Assigned:	09/24/2014	Date of Injury:	09/24/2010
Decision Date:	12/03/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	08/05/2014

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. The expert reviewer is Board Certified in Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 55 year old employee with date of injury of 9/24/2010. Medical records indicate the patient is undergoing treatment for cervical sprain/strain, myospasms; lumbar sprain/strain, myospasms; bilateral wrist sprain/strain, rule out wrist internal derangement; left knee sprain/strain, rule out internal derangement. Subjective complaints include moderate to severe dull, achy neck pain with stiffness, weakness and heaviness radiating to bilateral upper extremities. The upper extremities have numbness, tingling and weakness. Her pain is rated between a 5-9/10 on the pain scale. Her left wrist has dull, achy pain that radiates to all five digits with tingling and weakness. She has left knee pain with stiffness, heaviness and weakness. She has loss of sleep due to pain. Objective findings include tenderness to palpation of cervical paravertebral muscles and bilateral trapezii. Shoulder depression causes bilateral pain. Her cervical ranges of motion (ROM) are decreased and painful. There is tenderness to palpation of the lumbar paravertebral muscles and the lumbar ROM and decreased and painful. Kemp's test causes bilateral pain and Phalen's cause's pain. There is +3 tenderness to palpation of the left and right dorsal and volar wrists. The left and right wrists ROM are decreased and painful. The left knee has +3 tenderness to palpation of the anterior, medial and lateral knee and the ROM is decreased and painful. McMurray's causes pain. Treatment has consisted of Motrin, Terocin patches, topical creams, Aspirin, PT, acupuncture. The utilization review determination was rendered on 7/1/2014 recommending non-certification of a Multi Stim Unit with supplies x 5 month rental and an Aspen summit back brace (Purchase).

IMR ISSUES, DECISIONS AND RATIONALES

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

Multi Stim Unit with supplies x 5 month rental: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315,Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120.

Decision rationale: ACOEM guidelines state "Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists." MTUS further states regarding inferential units, "Not recommended as an isolated intervention" and details the criteria for selection:- Pain is ineffectively controlled due to diminished effectiveness of medications; or - Pain is ineffectively controlled with medications due to side effects; or - History of substance abuse; or - Significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment; or- Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). "If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits."The treating physician's progress notes do no indicate that the patients has poorly controlled pain, concerns for substance abuse, pain from postoperative conditions that limit ability to participate in exercise programs/treatments, or is unresponsive to conservative measures. As such, current request for Multi Stim Unit with supplies x 5 month rental is not medically necessary.

Aspen summit back brace (Purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (Lumbar and Thoracic), Lumbar Support

Decision rationale: ACOEM states, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG states, "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. Lumbar supports do not prevent LBP. 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. This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. ODG states for use as a 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). The patient is well beyond the acute phase of treatment and the treating physician has provided no documentation of spondylolisthesis or documented instability. As such the request for Aspen summit back brace (Purchase) is not medically necessary.