MAXIMUS Federal Services

Case Number:	CM14-0148304		
Date Assigned:	09/18/2014	Date of Injury:	05/18/2006
Decision Date:	11/26/2014	UR Denial Date:	09/03/2014
Priority:	Standard	Application Received:	09/12/2014

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 Occupational Medicine and is licensed to practice in California. 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:

Injured worker is a male with date of injury 5/18/2006. Per primary treating physician's progress report dated 6/26/2014, the injured worker complains of neck pain that radiates into both upper extremities as well as bilateral elbow pain. He also reports a history of chronic low back pain which radiates into both lower extremities equally. He currently rates his pain at 6-7/10 with medications and 7-8/10 without medications. He did receive his cervical pillow which has not been helping him. He continues to have difficulty sleeping due to the neck pain and he continues to snore. He has had one session of acupuncture which he has noted improvement in his pain symptoms. He continues to have numbness and tingling in all fingers of both hands in addition to neck pain with radiation into both upper extremities. On examination cervical range of motion is restricted with a forward flexion of 20 degrees, extension 10 degrees, left and right lateral side bending 10 degrees. There is cervical and lumbar paravertebral muscle spasm, and lumbar range of motion is restricted. Bilateral lower extremity strength is 5/5. Upper extremity strength is 4/5. He has decreased sensation in his C6 and C7 distribution as well as a positive Phalen's and a positive Tinel's. Diagnoses include 1) stenosis, cervical foraminal 2) spondylosis, cervical 3) herniated nucleus pulposis, lumbar.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multi-Stim Unit Plus Supplies For 5 Months Rental For The Neck, Low Back And Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) section Page(s): 118-120.

Decision rationale: The MTUS Guidelines do not recommend an interferential stimulator as an isolated treatment, however it may be useful for a subset of individuals that have not had success with pain medications. The evidence that an interferential stimulator is effective is not well supported in the literature, and studies that show benefit from use of the interferential stimulator are not well designed to clearly demonstrate cause and effect. The guidelines support the use of an interferential stimulator for a one month trial to determine if this treatment modality leads to increased functional improvement, less reported pain and medication reduction. The request is not for a one month trial however, and the unit is not recommended for use without the trial and document evidence of benefit.The request for Multi-Stim Unit Plus Supplies For 5 Months Rental For The Neck, Low Back And Upper Extremities is determined to not be medically necessary.

Cervical Kit: 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 Exercise section Page(s): 46,47.

Decision rationale: The MTUS Guidelines recommend the use of exercise. There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated. Such programs should emphasize education, independence, and the importance of an on-going exercise regime.A cervical kit is not essential to performing exercises for cervical injuries. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for cervical kit is determined to not be medically necessary.

Cervical Traction: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173,174.

Decision rationale: Per the MTUS Guidelines, there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and return of patients to activities of normal daily living. The request for cervical traction is determined to not be medically necessary.