

<b>Case Number:</b>	CM14-0184507		
<b>Date Assigned:</b>	11/10/2014	<b>Date of Injury:</b>	07/30/2014
<b>Decision Date:</b>	12/16/2014	<b>UR Denial Date:</b>	10/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2014

### 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 Family Medicine and is licensed to practice in Utah. 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:

The patient is a 35 year-old male. The patient's date of injury is 7/30/2014. The mechanism of injury was stated as cumulative trauma. The patient has been diagnosed with cervical and lumbar musculoligamentous strain/sprain with radiculitis, thoracic musculoligamentous strain/sprain, bilateral shoulder pain, right wrist pain, bilateral knee strain/sprain and ankle pain. It is unclear according to the clinical records what patient's treatments have included. The physical exam findings dated 9/18/2014 states there is tenderness over the C4, C5, C6 and C7 area of the cervical neck, with muscle spasms in the paracervical and trapezius. Cervical motion is decreased, with a positive cervical compression. A positive Straight Leg raise was also noted. There was tenderness over the anterior shoulder and at the biceps muscles and over the acromioclavicular joint. The patient's medications were not stated in records. The request is for lumbosacral brace, interferential unit and hold/cold therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbosacral brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for lumbar support. MTUS guidelines state the following: physical support for lumbar is not recommended. The request as written above is not indicated as a medical necessity to the patient at this time.

**Purchase of Interferential Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Interferential Current Stimulation

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Interferential unit and supplies. MTUS guidelines state the following: not recommended as an isolated intervention. It is unclear if this is an isolated intervention at this time. There is no supporting documentation. According to the clinical documentation provided and current MTUS guidelines; Interferential unit and supplies is not indicated as a medical necessity to the patient at this time.

**Purchase of hot or cold therapy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter Knee & Leg ( Acute & Chronic)

**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 and Thoracic, Cold/Heat Pack

**Decision rationale:** MTUS and other treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for a cold therapy unit. MTUS does not specifically mention a cold therapy unit, but does recommend at-home applications of heat and cold and would support hot and cold packs for acute pain. ODG indicates cold therapy units for certain post-op conditions, but does not recommend equipment to apply cold therapy to the chronic pain patient. There is no supporting documentation that would warrant the usage of a hold/cold unit. According to the clinical documentation provided and current MTUS guidelines; a hot/cold therapy unit is not indicated as a medical necessity to the patient at this time.