

Case Number:	CM15-0104356		
Date Assigned:	06/08/2015	Date of Injury:	01/06/2014
Decision Date:	07/08/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	06/01/2015

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: Connecticut, California, Virginia
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 67-year-old female, who sustained an industrial injury on January 6, 2014. She was diagnosed with cervicgia, hip sprain, lumbar and cervical disc displacement, lumbar spinal stenosis and a meniscal tear. Treatment included heat and cold therapy unit, heat and cold therapy wrap, a lumbar home rehab kit, a cervical home rehab kit and an elbow brace. Currently, the injured worker complained of increased lower back pain from prolonged sitting and standing. The treatment plan that was requested for authorization included a cervical home exercise rehabilitation kit, lumbar home exercise rehabilitation kit, right elbow brace, heat and cold unit for purchase and multi stimulator unit plus supplies rental.

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 x 5 month rental: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS
 Page(s): 114-116.

Decision rationale: With respect to chronic pain and according to the MTUS, TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for conditions including: Complex regional pain syndrome, neuropathic pain, phantom limb pain, spasticity, and multiple sclerosis. The MTUS states that although electrotherapeutic modalities are frequently used in the management of chronic low back pain, few studies were found to support their use. Most studies on TENS can be considered of relatively poor methodological quality. MTUS criteria for use include documentation of pain of at least three months duration and evidence of failure of other modalities in treating pain (including medications). In this case there are no provided records indicating that the patient has been diagnosed with a condition where use of TENS has shown proven benefit, and a treatment plan outlining short and long term goals for TENS therapy has not been established per the provided records. Therefore, at this time and based on the provided records, the request for TENS for five months cannot be considered medically necessary.

Heat/cold unit for purchase: Upheld

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

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 chapter, heat therapy.

Decision rationale: The Official Disability Guidelines address the use of heat therapy and recommend it as an option. Recent data supports that the Thermacare heat wrap is more effective than other tested products. While the guidelines state that that heat therapy has been found to be helpful for pain reduction and return to normal function, there are no medical records provided to justify the request. At this time, given the lack of objective exam findings provided in the case documents from the primary treating physician, it appears that the decision to non-certify the request per utilization review is reasonable due to lack of evidence supporting the request. Therefore, the request is not considered medically necessary.

Right elbow brace: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow bracing/splinting.

Decision rationale: The ODG recommends bracing/splinting for cubital tunnel syndrome (ulnar nerve entrapment), including a splint or foam elbow pad worn at night (to limit movement and reduce irritation), and/or an elbow pad (to protect against chronic irritation from

hard surfaces). In this case, the patient's diagnosis is not clear based on the provided records, and without further clarification, there is not enough information to support the request. Therefore, at this time, given the provided documents, the request is not considered medically necessary.

Lumbar home exercise rehab kit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy and manipulation Page(s): 58-59.

Decision rationale: The MTUS Chronic Pain Management Guidelines (pg 58-59) indicate that manual therapy and manipulation are recommended as options in back pain. With respect to therapeutic care, the MTUS recommends a trial of 6 visits over 2 weeks, with evidence of objective functional improvement allowing for up to 18 visits over 6-8 weeks. If the case is considered a recurrence/flare-up, the guidelines similarly indicate a need to evaluate treatment success. In either case, whether considered acute or recurrent, the patient needs to be evaluated for functional improvement. In this case, there is not enough information in the provided documents to support a request for physical therapy or a home exercise program, and the requested home exercise kits are not considered medically necessary without further clarification.

Cervical home exercise rehab kit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy and manipulation Page(s): 58-59.

Decision rationale: The MTUS Chronic Pain Management Guidelines (pg 58-59) indicate that manual therapy and manipulation are recommended as options in back pain. With respect to therapeutic care, the MTUS recommends a trial of 6 visits over 2 weeks, with evidence of objective functional improvement allowing for up to 18 visits over 6-8 weeks. If the case is considered a recurrence/flare-up, the guidelines similarly indicate a need to evaluate treatment success. In either case, whether considered acute or recurrent, the patient needs to be evaluated for functional improvement. In this case, there is not enough information in the provided documents to support a request for physical therapy or a home exercise program, and the requested home exercise kits are not considered medically necessary without further clarification.