

Case Number:	CM15-0017316		
Date Assigned:	02/03/2015	Date of Injury:	02/21/2012
Decision Date:	03/30/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/26/2015

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 53 year old male, who sustained an industrial injury on 2/21/12. He has reported neck, back, bilateral knees and shoulder injuries. The diagnoses have included cervical sprain/strain, lumbar radiculopathy, lumbar strain/sprain, rotator cuff syndrome, shoulder sprain/strain, knee strain/sprain and insomnia. Treatment to date has included medications, conservative measures, Home Exercise Program (HEP) and diagnostics. Currently, the injured worker complains of right shoulder pain rated 8/10 and 7/10 with medications, bilateral knee pain right greater than left, rated 8/10 and 7/10 with medication, and low back pain that radiates to right lower extremity rated 8/10 and 7/10 with medication. He states that the neck is feeling better but he complained of lack of sleep. Physical exam revealed decreased range of motion cervical and lumbar areas with tenderness to palpation and pain. There was tenderness to palpation over the acromioclavicular joint, bicipital joint and post scapula. There was tenderness upon palpation of bilateral knees without swelling. The range of motion was decreased with pain noted. There were no diagnostic reports noted. On 1/23/14 Utilization Review non-certified a request for Multi-Stimulator Unit 5 Month Rental and Supplies (for Low Back Injury) and Back Brace, noting the medical necessity was not established. The (MTUS) Medical Treatment Utilization Schedule, (ACOEM) Occupational Medicine Practice Guidelines and Official Disability Guidelines (ODG) were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multi-Stim Unit 5 Month Rental and Supplies (for Low Back Injury): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

Decision rationale: Per the reports provided the patient presents with right shoulder pain, bilateral knee pain right greater than left, and low back pain that radiates to right lower extremity. The current request is for MULTI-STIM UNIT 5 MONTH RENTAL AND SUPPLIES "FOR LOW BACK INJURY" per the 10/23/14 report. The RFA is not included. As of 10/23/14 the patient is to remain off work until 12/08/14. MTUS guidelines Transcutaneous electrotherapy pages 114, 115, TENS units have no proven efficacy in treating chronic pain and are not recommend as a primary treatment modality, but a one month home based trial may be considered for specific diagnosis of neuropathy, CRPS, spasticity, phantom limb pain, or Multiple Sclerosis. MTUS also quotes a recent meta-analysis of electrical nerve stimulation for chronic musculoskeletal pain, but concludes that the design of the study had questionable methodology and the results require further evaluation before application to specific clinical practice. The requested unit is indicated for the neuropathic pain that is documented for this patient. The unit does not appear to be a primary treatment modality as the patient is prescribed a medication regimen that includes NSAID. However, the MTUS guidelines allow a 30 day home trial and this request is for 5 months. There is no evidence that the patient has previously trialed TENS. In this case, the request IS NOT medically necessary.

Back Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter, Lumbar supports

Decision rationale: Per the reports provided the patient presents with right shoulder pain, bilateral knee pain right greater than left, and low back pain that radiates to right lower extremity. The current request is for BACK BRACE per the 10/23/14 report which specifies "Aspen" back brace. The RFA is not included. The 12/23/14 utilization review states decision was made regarding a lumbar brace. As of 10/23/14 the patient is to remain off work until 12/08/14. ACOEM guidelines page 301 on lumbar bracing state, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Low Back - Lumbar & Thoracic Chapter, lumbar supports topic, states, "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)." For post-operative bracing, ODG states, "Under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace, if any, depending on the experience and expertise of the treating physician."The reports provided for review do not discuss the reason for this request. There is no documentation the patient is being treated for acute symptom relief, compression fractures, spondylolistheses or instability. Nonspecific LBP has low-quality evidence for use of a brace. There is no evidence that the patient is s/p back surgery. In this case, the request IS NOT medically necessary.