Case Number:	CM15-0073662		
Date Assigned:	04/23/2015	**Date of Injury:**	09/03/2014
Decision Date:	05/21/2015	**UR Denial Date:**	03/17/2015
Priority:	Standard	**Application Received:**	04/17/2015

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: New Jersey, Alabama, California
Certification(s)/Specialty: Neurology, Neuromuscular 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 58 year old female, who sustained an industrial injury on 9/3/2014. She reported back pain after tripping and falling. The injured worker was diagnosed as having head pain, cervical musculoligamentous strain/sprain with radiculitis, thoracic musculoligamentous strain/sprain, and lumbosacral musculoligamentous strain/sprain with radiculitis, right shoulder strain/sprain, right shoulder tendinosis, right shoulder adhesive capsulitis, bilateral elbow strain/sprain, and right hip strain/sprain. Treatment to date has included medications, and physical therapy. The request is for hot & cold therapy unit, physical therapy evaluation and treatment, and Motrin. On 2/5/2015, she complained of headaches, neck, upper, mid and lower back, right shoulder and arm, bilateral elbow and forearm, and right hip and thigh pain. She rated her pain as 8/10 which was an increase from her previous visit. On 3/12/2015, she continued with similar complaints, with report of increased mid-upper-lower back pain now rated 8/10 from 7/10. The records indicate she reported treatment helps, and physical therapy helps to decrease her pain and tenderness. The treatment plan included: continuing physical therapy, and Tramadol.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot & Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation URL (www.ncbi.nim.nih.gov/pmc/articles/PMC1320244)Official Disability Guidelines: Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cold/heat packs.?(http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#SPECT).

Decision rationale: According to ODG guidelines, cold therapy is recommended as an option for acute pain, At-home local applications of cold packs in first few days of acute complaint, thereafter applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) See also Heat therapy; Biofreeze cryotherapy gel. There is no evidence to support the efficacy of hot and cold therapy in this patient. There is not enough documentation relevant to the patient work injury to determine the medical necessity for cold therapy. There are no controlled studies supporting the use of hot/cold therapy in back pain. Therefore, the request for Hot & Cold Therapy Unit is not medically necessary.

Motrin 800 mg Qty 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non steroidal anti inflammatory drugs) Page(s): 67-68, 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen Page(s): 66.

Decision rationale: According to MTUS guidelines, Motrin is indicated for relief of pain related to osteoathritis and back pain for the lowest dose and shortest period of time. There is no documentation that the shortest and the lowest dose of Motrin were used. There is no clear documentation of pain and functional improvement with NSAID use. Therefore, the prescription of Motrin 800mg #90 is not medically necessary.

Physical Therapy Evaluation/Treatment, 2 times weekly for 6 weeks, Cervical Spine, Thoracic Spine, Lumbar Spine, Right Shoulder, Right Elbow, Right Hip: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: According to MTUS guidelines, Physical Medicine is recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instructions. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices.(Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)There is no documentation of the efficacy and outcome of previous physical therapy sessions. There are no recent objective findings that support musculoskeletal dysfunction requiring additional physical therapy. There is no documentation that the patient cannot perform home exercise. Therefore, the request for Physical Therapy Evaluation/Treatment, 2 times weekly for 6 weeks, Cervical Spine, Thoracic Spine, Lumbar Spine, Right Shoulder, Right Elbow, Right Hip is not medically necessary.