WellComp
Managed Care Services

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July 27, 2016

Mullen & Filippi, LLP
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## Utilization Review Recommendation
## Certified
**Referral Number –** 0002-1202-4200

**Notification Date:** 7/27/2016

| | |
|---|---|
| Claimant Name: Rosario Santillan | Client: Tower Castlepoint NSM Staffing |
| Claim Number: TWCS-1588 | Adjuster:Transitional Examiner 1 |
| Date of Injury: 2/22/2013 | |

| | |
|---|---|
| Date Request Received: 7/13/2016 | UR Nurse: Windy Gonzales RN |
| Date Completed Medical Received: 07/13/2016 | Physician Reviewer: Joseph Braun |
| Decision Date: 7/27/2016 | |

**Requester:** Vlad Gendelman, MD

WellComp has been asked to review the treatment request listed below for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Advisor made the following determination recommendation.

| Services Requested | Determination |
|---|---|
| WATER CIRC COLD PAD W PUMP (DOS: 09/25/2015 - 10/01/2015) | Certified |
| Pad water circulating heat u (DOS: 09/25/2015) | Certified |
| Crutch underarm pair no wood | Certified |
| DELIVERY/SET UP/DISPENSING | Certified |

**Diagnosis Codes/Descriptions:**
T14.90-Injury, unspecified

**Services Approved From:** 9/25/2015 - 10/1/2015

The full clinical rationale for the determination follows in the Physician Advisor Determination.

While services were deemed medically appropriate by Utilization Review, billing for services is subject to adjudication via the Official Medical Fee Schedule and guidelines.

This evaluation has been conducted entirely on the basis of the medical information/documentation provided for review. WellComp's decisions are based on the recommendation of the CA MTUS. If it is "silent" on an issue, one or more of the following evidence-based guidelines may be consulted: ACOEM Guidelines, Official Disability Guidelines, guidelines from specialty societies or other national organizations.

These findings apply only to the specific treatment proposed by the treating physician or facility. A separate review will be necessary if the treating physician proposes additional types of treatment. The treating physician or facility should contact WellComp at 800-580-2273 if additional types of treatment are proposed.

WellComp's utilization review findings are intended solely as clinical opinions to determine whether proposed treatment is medically reasonable and necessary, based on the information provided. WellComp expresses no legal opinion through these findings regarding the liability of any party to pay for any treatment that may be provided to a non-compensable area. WellComp's authorization or non-authorization of treatment or procedures is not intended in any way to relieve the treating physician's responsibility for patient care. Any dispute shall be resolved in accordance with Labor Code Section 4610.5 and 4610.6.

For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401

MPN preauthorization requests received from an out-of-network provider without approval from the claims examiner or network administrator will be processed based on medical necessity only. Authorization(s) and medical necessity approval(s) of a procedure or service do not guarantee payment of all or part of your charges. Out-of-network provider treatment for MPN claimants requires network approval.

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## Physician Advisor Determination

0002-1202-4200

Date of Physician Determination: 7/27/2016

Treatment Requested:

- (7) WATER CIRC COLD PAD W PUMP (DOS: 09/25/2015 - 10/01/2015)
- (1) Pad water circulating heat u (DOS: 09/25/2015)
- (1) Crutch underarm pair no wood
- (1) DELIVERY/SET UP/DISPENSING

List of Medical Records Reviewed:

- Health claim insurance (DOS: 09/25/2015 - 10/01/2015) (2950158_6202668_TWCS-1588_SubmitPay_022_0C5C2EEF.pdf)
- PR-2 09/24/2015 Dr. Gendelman (53817297_0C4A05CF.pdf)

Clinical Summary: This claimant was injured in 2013. Request is for circulating water pump water pad, crutches and delivery. On 09/24/2015, the claimant complains of headaches, as well as pain in the neck, mid/upper back, lower back, and left knee. On a scale of 0 to 10, with 10 representing the worst, her headaches are rated as 6/ 10 per the VAS scale, which have remained the same since her last visit; 6/ 10 in the neck, which has decreased from 8 / 10 on the last visit; 6 / 10 in the mid/upper back, which has increased from 2/ 10 on the last visit; and 8/ 10 in the lower back and left knee, which has remained the same since her last visit. There is grade 2 tenderness to palpation over the paraspinal muscles, which has remained the same since her last visit to cervical, thoracic, lumbar spine, and left knee. There is restricted range of motion. Cervical compression test is positive. Straight leg raise test is positive bilaterally. There is restricted range of motion. McMurray's test is positive. The date of injury is listed as 02/22/2013. The claimant is documented to be female, 49 years of age who sustained injury while loading and unloading boxes, when she felt a pull in her back which caused pain to develop as the day progressed. According to Primary Treating Physician's Progress Report (PR-2) dated 09/24/2015, the claimant complains of headaches, as well as pain in the neck, mid/upper back, lower back, and left knee. On a scale of 0 to 10, with 10 representing the worst, her headaches are rated as 6/ 10 per the VAS scale, which have remained the same since her last visit; 6/ 10 in the neck, which has decreased from 8 / 10 on the last visit; 6 / 10 in the mid/upper back, which has increased from 2/ 10 on the last visit; and 8/ 10 in the lower back and left knee, which has remained the same since her last visit. There is grade 2 tenderness to palpation over the paraspinal muscles, which has remained the same since her last visit to cervical, thoracic, lumbar spine, and left knee. There is restricted range of motion. Cervical compression test is positive. Straight leg raise test is positive bilaterally. There is restricted range of motion. McMurray's test is positive.

Decision: Certified

Clinical Rationale: California does not support the use of these devices except around surgery, and then only a rental and not purchase. Clinical provided does not definitively show the claimant had surgery,

Crutches are medically reasonable and therefore authorized.

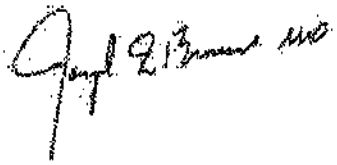
EBM Citations: California cryotherapy

Not Recommended for Low Back Pain (Insufficient Evidence (I))
Routine use of cryotherapies in health care provider offices or home use of a high-tech device for the treatment of LBP is not recommended.

ODG on Cryotherapy: Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs.

ODG Walking aids (canes, crutches, braces, orthoses, & walkers)

Recommended, as indicated below. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. (Van der Esch, 2003)



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I attest to having a scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review, and that I have current, relevant experience and/or knowledge to render a determination for the case under review.