

Case Number:	CM13-0017914		
Date Assigned:	01/22/2014	Date of Injury:	06/26/2012
Decision Date:	07/08/2014	UR Denial Date:	08/13/2013
Priority:	Standard	Application Received:	08/28/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 56 year-old female with a 6/26/13 date of injury. She has been diagnosed with lumbar radiculopathy; myalgia; chronic pain; T12 compression fracture with disc herniation and compression of cord. On 8/13/13 UR provided a decision recommending non-certification for a cold therapy unit rental x60 days, and interferential unit rental for 60 days following a right L4-S1 epidural steroid injection (ESI). According to the 8/20/13 pain management report from Dr Baker, the patient presents with low back pain radiating down both lower extremities and neck pain that radiates down both upper extremities. The patient's pain was described as 8-9/10 with medications, and 10/10 without. The patient on Tramadol ER 150mg qd; gabapentin 600mg; The ESI was approved and performed on 9/3/13. On the 9/17/13 report, the patient complains of 10/10 pain with and without medications. The patient was treated with vitamin B12 injection and a toradol injection and hydrocodone 10/325mg tid was added. On 10/15/13, the patient continued to report 10/10 pain with or without medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

COLD THERAPY UNIT RENTAL FOR 60 DAYS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on the Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold Number: 0297 Policy Aetna considers the use of cryoanalgesia medically necessary for the temporary relief of pain due to chronic refractory trigeminal neuralgia.

Decision rationale: The patient presents with neck pain radiating to both upper extremities, and lower back pain radiating to both lower extremities. The request is for a 60-day rental of a cold therapy unit following the lumbar TFESI. MTUS ACOEM recommends cold therapy during the first few days of the acute complaints. The patient's injury was in 2012, and is beyond the acute phase. ODG guidelines does not discuss mechanical cold therapy units for the lower back, but do recommend hot/cold packs. Aetna guidelines were consulted. Aetna considers passive hot and cold therapy medically necessary. Mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. The request for a cold therapy unit is not in accordance with Aetna guidelines. The request is not medically necessary.

INTERFERENTIAL UNIT RENTAL FOR 60 DAYS: Upheld

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

MAXIMUS guideline: Decision based on the Chronic Pain Medical Treatment Guidelines, TENS Section, pages 114-121.

Decision rationale: The patient presents with neck pain radiating to both upper extremities, and lower back pain radiating to both lower extremities. The request is for a 60-day rental of an interferential unit following the lumbar TFESI. The MTUS guidelines state a 1-month trial of interfeferential may be appropriate if the pain is ineffectively controlled due to diminished effects of medications, or side effects, or history of substance abuse or if postoperative condition limits ability to perform exercises. The medical reports prior to the TFESI (9/3/13) do not document diminished effects of medications, or substance abuse. But after the TFESI, it appears that tramadol, gabapentin, toradol, and hydrocodone were not effective. The patient meets the MTUS criteria for a trial of interfeferential therapy, However, the request as written is for a 60-day rental, which exceeds the MTUS recommendation for a 1-month trial. The request is not medically necessary.