

<b>Case Number:</b>	CM13-0021643		
<b>Date Assigned:</b>	11/13/2013	<b>Date of Injury:</b>	04/15/2012
<b>Decision Date:</b>	01/10/2014	<b>UR Denial Date:</b>	08/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois, Indiana and Texas. 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 physician 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 57-year-old male who reported an injury on 04/15/2012. The patient's symptoms are noted as thoracolumbar junction pain and right side back pain. Objective findings include pain with flexion and extension of the lumbar spine, active spasms, tenderness to palpation, tight hamstrings, and negative straight leg raise testing. The patient's diagnoses are listed as spondylosis of the lumbar spine, musculoligamentous strain of the lumbar spine, and diffuse posterior disc bulge at L5-S1. It was noted that a ThermoCool hot and cold contrast therapy with compression was being requested for a period of 60 days for pain control, reduction of inflammation, and increased circulation. It was also noted that a request was being made for an X-force stimulator unit which was noted to be a dual unit, offering TEJS and TENS functions that both use electrical stimulation to combat pain found in the joint capsule.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ice heat unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation ODG, Low Back (updated 5/10/13) Cold/heat packs .

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation the Official Disability Guidelines (ODG), Knee & Leg, continuous flow cryotherapy..

**Decision rationale:** The patient was noted to have symptoms to include back pain. A request was made for a compression heat and cold therapy unit. CA MTUS/ACOEM states at-home local applications of cold in first few days of acute complaint; thereafter, applications of heat or cold. Official Disability Guidelines do not address cold therapy units for low back conditions; however, continuous flow cryotherapy units are discussed in the knee chapter. It states that these units are recommended as an option after surgery, but not for nonsurgical treatment. It states that cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use in the postoperative setting; however, the effect on more frequently treated acute injuries such as muscle strains and contusions has not been fully evaluated. As cryotherapy units are not recommended for the low back, and are only recommended as an option after surgery for the treatment of other conditions, the request is not supported by guidelines. Therefore, the requested service is non-certified.

**X-force stimulator:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy: Interferential Current Stimulation (ICS) Page(s): 114,118.

**Decision rationale:** The patient has symptoms of back pain. A request was made for an X-force stimulator, which was noted to be a dual unit, offering TEJS and TENS functions, and is addressed under interferential stimulation in the California MTUS Guidelines. The guidelines state that interferential current stimulation (ICS) is not recommended as an isolated intervention. It is noted that there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The guidelines further specify that this treatment would possibly be appropriate for pain that is ineffectively controlled due to diminished effectiveness of medications, ineffectively controlled pain with medications due to side effects, or history of substance abuse, or significant pain from postoperative conditions which limits the ability to perform exercise programs and physical therapy treatment, or otherwise unresponsive to conservative measures. As the request for the X-force stimulator failed to show detailed documentation as required by California MTUS Guidelines for transcutaneous electrotherapy, its use is not supported at this time. Therefore, the requested service is non-certified.