

Case Number:	CM13-0031263		
Date Assigned:	12/04/2013	Date of Injury:	12/24/2010
Decision Date:	07/30/2014	UR Denial Date:	09/17/2013
Priority:	Standard	Application Received:	10/03/2013

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 Neurology 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 Injured Worker (IW) is a 49-year old female who reports sustaining an injury on 12/24/10 when pulling down a box from an over-head shelf that was heavier than anticipated, resulting in injury to both shoulders and lower back. The IW continues to suffer pain associated with these injuries. Documents reviewed indicate that an MRI of the right shoulder (3/20/13) reveals extensive degeneration and tendinosis of the supraspinatus tendon. A left shoulder MRI (2/8/13) reveals moderate tendinosis of the supraspinatus tendon and a SLAP II tear of the superior labrum. A lumbar spine MRI (2/18/13) indicates at L3-4 a 2-3 mm far lateral intraforaminal disc protrusion and mild-to-moderate facet hypertrophy, and a 2 mm broad based annulus bulge with moderate facet and ligamentous hypertrophy resulting in borderline central canal stenosis and mild lateral recess and proximal neuroforamen encroachment bilaterally. There is mild-to-moderate facet hypertrophy at L5-S1. EMG and NCV studies (6/27/13) of cervical spine and upper extremities bilaterally demonstrate evidence of left carpal tunnel syndrome and medial nerve entrapment at the wrist, and right carpal tunnel syndrome with median nerve entrapment at the wrist affecting sensory and motor components. Studies of the lumbar spine and bilateral lower extremities provide evidence of acute L5 radiculopathy on the left. Clinical presentation as documented in physician's reports support these findings. The IW has received physical therapy, chiropractic therapy, and acupuncture in the past. Epidural injections have been recommended but there is no documentation indicating if these have been administered and to what effect. Records indicate that the IW currently uses Norco 10/325 mg, Ambien, temazepam 30 mg, Plavix 75 mg, Flexeril 10 mg, Xanax as needed, and stool softeners. She has a history of bowel obstruction secondary to pain medications requiring surgery in December 2012. Past medications have included Naproxen, Cidaflex, and Prilosec. The treating physician requested approval for

the purchase of x-force stimulator, and solar care infrared heating pad on 9/10/13, both requests were non-certified on 9/30/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

X FORCE STIMULATOR PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : CHRONIC PAIN GUIDELINES, ,.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: X-Force stimulator is a proprietary-branded TENS unit. According to the Chronic Pain Medical Treatment Guidelines regarding the use of transcutaneous electrotherapy (pp. 114-121), the use (as necessarily implied by the purchase, in this case) of a TENS unit is not recommended without demonstration of a one-month trial period documenting how often the unit was used and to what effect regarding pain relief and improvement in function. Rental is preferred over purchase for the purpose of this trial. During this trial, other ongoing pain treatment and medication use must be well-documented. TENS therapy itself is not recommended as a primary treatment modality but it may be considered if used as an adjunct therapy to other evidence-based functional restorative programs. One-month home-based treatment trial may in fact be recommended for the treatment of neuropathic pain, though studies are inconclusive with regard to stimulation parameters most likely to be effective for optimum pain relief, and published evidence is lacking regarding outcome effectiveness beyond single-treatment. Nevertheless, a treatment plan indicating the long- and short-term goals of TENS unit therapy has not been submitted, and there is no record indicating that a trial conducted per conditions outlined by the Guidelines has been conducted.

SOLAR CARE INFRARED HEATING PAD PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): MTUS: ACOEM GUIDELINES, 12, 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203; 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Procedure.

Decision rationale: The MTUS' Chronic Pain Medical Treatment Guidelines do not appear to address the specific use (as implied by the request for purchase) of infrared heating pads. The ACOEM's Chapters 9 (Shoulder complaints, p. 203) and 12 (Lower back complaints, p. 300) indicate that at-home local applications of heat or ice packs may be effective for treatment before or after exercise, and that such applications are as effective as any tendered by a therapist. There has not been documentation submitted to indicate that other heat modalities have been tried nor any clinical evidence indicating that the kind of deep-heating that infrared therapy delivers is

warranted. The ODG (Low Back Procedure Summary) indicates that IR therapy is not recommended over other heat modalities, but states that in cases where deeper heating is required, a limited trial use of IR may be requested specific to the treatment of acute lower back pain as an adjunct therapy to other evidence-based therapies. The medical necessity for the purchase of a solar care infrared heating pad has not been established in the documentation submitted with this request. As such, the request is not medically necessary.