

Case Number:	CM13-0072537		
Date Assigned:	01/31/2014	Date of Injury:	04/13/2013
Decision Date:	11/26/2014	UR Denial Date:	12/20/2013
Priority:	Standard	Application Received:	12/31/2013

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 Family Medicine, 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:

This is a 38-year-old male patient who reported an industrial injury on 4/13/2013, 19 months ago, attributed to the performance of his usual and customary job tasks. The patient was being treated for the diagnoses of lumbar spine disc protrusion; lumbar radiculopathy; and mild spasm. The patient complained of intermittent low back pain with reported numbness and tingling radiating to the left lower extremity. The patient received ongoing physical therapy, acupuncture, medications, and activity modifications as conservative treatment. The objective findings on examination included normal gait, no tenderness over spasms in the thoracic spine; tenderness to palpation with spasms of the paraspinals to the lumbar spine; diminished range of motion to the lumbar spine; negative SLR bilaterally; sensation and reflexes were intact. The treatment plan included a request for a TENS unit and a request for a hot cold unit with a wrap.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 203; 300, Chronic Pain Treatment Guidelines TENS

unit chronic pain Page(s): 114-117. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) forearm, wrist, hand--TENS unit; Pain chapter--TENS unit

Decision rationale: The requesting provider did not provide subjective/objective evidence to support the medical necessity of the TENS Unit or the electronic muscle stimulator for the treatment of the back other than the recommended 30-day trial rental. The ACOEM Guidelines do not recommend the use of TENS Units for neck, shoulder, elbow, or wrist as there is no objective evidence available to support their use. There is no demonstrated medical necessity for a TENS unit is a freestanding treatment modality without the documentation of a functional restoration effort. It is recommended that the patient undergo a 30-day trial to demonstrate functional improvement prior to the purchase of a TENS unit for the treatment of the lumbar spine chronic pain issues. There is no justification for the use of the 4-lead TENS unit as required by the CA MTUS. The use of the TENS unit for the treatment for the wrist/hand/forearm is not recommended by the CA MTUS or the ACOEM Guidelines. There is no objective evidence provided to support the medical necessity of the requested TENS Unit or electric muscle stimulator for the treatment of the back for the effects of the industrial injury. There was no documented functional improvement with use of a TENS unit in physical therapy; no documented 30-day trial rental; and no documented ongoing restoration program directed to the lower back. The TENS unit is directed to chronic back pain issues with a date of injury 19 months ago. The CA MTUS and the Official Disability Guidelines only recommends the use of the TENS unit for chronic lower back pain with a demonstrated exercise program for conditioning and strengthening. The TENS Unit is recommended for only chronic intractable pain. There was no provided documentation that the patient was participating in a self-directed home exercise program. The ACOEM Guidelines revised back chapter 4/07/08 does recommend the use of the TENS Unit for the treatment of chronic lower back pain; however, it must be as an adjunct to a functional rehabilitation program and ongoing exercise program. The CA MTUS only recommend the use of the TENS unit for chronic lower back pain with a demonstrated exercise program for conditioning and strengthening. There are no recommendations for the use of the TENS Unit in the treatment of the back. There is no objective evidence provided by the requesting provider that the same results cannot be achieved with a home exercise program established for functional rehabilitation with strengthening and conditioning directed to the hand. There is no demonstrated medical necessity for the purchase of a TENS for the rehabilitation of the chronic pain to the lower back without an initial 30-day trial to demonstrate evidence of functional improvement. Therefore, this request is not medically necessary.

HOT AND COLD PACK/WRAP OR THERMAL COMBO UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation AETNA CLINICAL POLICY BULLETIN: CRYOANALGESIA AND THERAPEUTIC COLD

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 300; 338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg chapter cold heat packs; continuous flow cryotherapy; Low back chapter cold/head packs

Decision rationale: The use of the cold/hot circulation units with a wrap are recommended by evidence-based guidelines for hospital use but not for home use. There is no demonstrated medical necessity for this cold/hot therapy unit with appliance to be provided to the patient subsequent to the lower back sprain/strain for home treatment as opposed to the conventional treatment with cold/hot packs. The medical necessity of the DME for the home treatment of the patient was not supported with objective evidence to support medical necessity. There is no objective evidence to support the home use of the requested cold/hot therapy system as opposed to the customary RICE for the treatment of pain and inflammation. There was no clinical documentation provided to support the medical necessity of the requested DME in excess of the recommendations of the California MTUS. The use of a cold/hot circulation pump is not demonstrated to be medically necessary for the treatment of chronic lower back pain attributed to lumbar spine DDD. There is no demonstrated medical necessity for the purchase of a cold/hot circulation unit for the treatment of the lumbar spine for the cited. The cold/hot therapy units are not medically necessary for the treatment of the lumbar spine sprain/strains, as alternatives for the delivery of heat and cold to the back are readily available. The request for authorization of the cold/hot therapy by name brand is not supported with objective medically based evidence to support medical necessity. There is no provided objective evidence to support the medical necessity of the requested cold/hot unit as opposed to the more conventional methods for the delivery of cold/hot for the cited surgical intervention rehabilitation. The CA MTUS; the ACOEM Guidelines, and the ODG recommend hot or cold packs for the application of therapeutic cold/hot or heat. The use of hot or cold/hot is not generally considered body part specific. The Official Disability Guidelines chapter on the knee and lower back states a good example of general use for hot or cold. The issue related to the request for authorization is whether an elaborate mechanical compression device is necessary as opposed to the recommended hot or cold pack. There is no demonstrated medical necessity for the requested cold/hot unit for the treatment of the postoperative lumbar spine. There is no demonstrated medical necessity for the requested hot/cold unit for the treatment of the reported chronic low back pain for the diagnosis of lumbar radiculopathy and mild spasms. Therefore, this request is not medically necessary.