

<b>Case Number:</b>	CM14-0000287		
<b>Date Assigned:</b>	01/10/2014	<b>Date of Injury:</b>	09/29/2013
<b>Decision Date:</b>	06/05/2014	<b>UR Denial Date:</b>	12/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2013

### 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 Sports Medicine and is licensed to practice in 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 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 is a 35 year old female with a reported date of injury on 09/29/2013. Mechanism of injury was a slip and fall injury on a wet floor at her place of employment. The injured worker stated she had immediate sharp shooting pain in her lower back. The injured worker reported injury to low back, right knee, right ankle and right wrist. The injured worker's exam revealed lumbar spine normal lordosis. There was no inflammation, swelling, redness or bruising and straight leg raising test was negative. Range of motion for lumbar spine was flexion 15 degrees, extension 15 degrees, Right flexion 10 degrees, left flexion 10 degrees, right rotation 15 degrees, and left rotation 10 degrees. Range of motion is limited due to pain in all planes. Right wrist inspection revealed no inflammation, swelling, redness or bruising. Ranges of motion were measured as followed for the right wrist. Flexion 60 degrees, extension 70 degrees, ulnar deviation 30 degrees, and radial deviation 20 degrees. Range of motion was limited due to pain in all planes. Right knee exam revealed no inflammation, swelling, redness or bruising. There was tenderness to palpation present over the medial and lateral epicondylar regions, AP drawer test was negative. Range of motion was meandered as followed, flexion 90 degrees and extension 0 degrees. Range of motion was limited upon all planes. Right ankle exam revealed no inflammation, swelling, redness or bruising. There was tenderness to palpation present over the medial and lateral aspects of the ankle. Range of motion was measured as dorsiflexion 30 degrees, plantar flexion 20 degrees, inversion 20 degrees and eversion 10 degrees. Range of motion was limited due to pain in all planes. The injured worker was diagnosed with lumbar spine strain/sprain, right knee strain/sprain, right ankle strain/sprain, right wrist strain/sprain, and anxiety. The injured worker was given a compound cream that consist of capsaicin, flurbiprofen, tramadol, camphor, menthol. The injured worker was also prescribed naproxen, and omeprazole. The request for authorization form was signed on 12/17/2013.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MONTHLY SUPPLIES:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Continuous Cold Therapy.

**Decision rationale:** The request for monthly supplies is in conjunction with the request for a cold therapy unit. As the requested cold therapy unit is not recommended, monthly supplies would not be indicated. As such, the request for Monthly Supplies is not medically necessary.

**COLD THERAPY 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 Official Disability Guidelines (ODG), Low Back, Cold/heat packs.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Continuous Cold Therapy.

**Decision rationale:** The injured worker had injuries to her low back, right wrist, right knee and right ankle. The Official Disability Guidelines (ODG) recommend cold therapy for carpal tunnel syndrome. The use of cold therapy is recommended as an option only in the postoperative setting, with regular assessment to avoid frostbite. Postoperative use generally should be no more than 7 days, including home use. The use of cold therapy is recommended for use after surgery. There is no indication of recent surgery. Also there is duration included in the request. Therefore, the request for Cold Therapy is not medically necessary.

**INTERSPEC IF II:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118, 120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION (ICS) Page(s): 118.

**Decision rationale:** The injured worker stated she had immediate sharp shooting pain in her lower back. The injured worker reported injury to low back, right knee, right ankle and right wrist. The injured worker's exam revealed lumbar spine normal lordosis. The California MTUS

states the use of Interferential Current Stimulations (ICS) is not recommended as an isolated intervention. 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. There is no clinical documentation to note conservative care or results of such care. Therefore, the request for InterspecIF II is not medically necessary.