

Case Number:	CM14-0100076		
Date Assigned:	07/28/2014	Date of Injury:	02/27/2014
Decision Date:	08/29/2014	UR Denial Date:	06/24/2014
Priority:	Standard	Application Received:	06/30/2014

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 Occupational 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:

The patient is a 45-year-old female who has submitted a claim for lumbar spine discopathy, lumbar spine radiculopathy, lumbar facet syndrome, and bilateral sacroiliac joint arthropathy associated with an industrial injury date of 2/27/14. Medical records from 3/4/14 to 6/30/14 were reviewed and showed that the patient complained of chronic right low back pain graded 8-9/10 radiating down bilateral lower legs, greater on the right side. Numbness in the right buttock and hip with sitting accompanied the back pain. Physical examination revealed tenderness upon palpation over the lumbar paraspinal muscles and L4-S1 facet. A lumbar spine MRI dated 4/4/14 revealed L5-S1 disc herniation with bilateral neural foraminal stenosis and L4-5 disc protrusion with mild bilateral recess stenosis. Kemp's test was positive. Straight leg testing in a seated position was positive at 60 degrees on the right and 70 degrees on the left leg. Straight leg testing test in a supine position was positive at 50 degrees on the right and 60 degrees on the left leg. Sensation to light touch was decreased along the L5 dermatomal distribution bilaterally. An EMG/NCV study of the bilateral lower extremities dated 4/9/14 revealed bilateral L5 radiculopathy. Treatment to date has included physical therapy, aquatic therapy, and pain medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF Unit and supplies (rental or purchase): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: According to the California MTUS Chronic Pain Treatment Guidelines, Interferential Current Stimulation (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. Although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support Interferential current stimulation for treatment of these conditions. In this case, there was no documentation of active participation in a home exercise program by the patient. The guidelines clearly state that ICS is not recommended as an isolated form of intervention. Therefore, the request is not medically necessary.

Cold therapy unit (rental or purchase): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary last updated 5/12/14; ODG-TWC Knee and Leg Procedure Summary last updated 6/5/14.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

Decision rationale: The Aetna Clinical Policy Bulletin considers passive cold compression therapy units experimental and investigational because their effectiveness for indications has not been established. The use of hot/ice machines and similar devices are experimental and investigational for reducing pain and swelling after surgery or injury. Studies failed to show that these devices offer any benefit over standard cryotherapy with ice bags/packs. In this case, it is unclear as to why standard ice bags/packs application will not suffice for pain relief. Therefore, the request is not medically necessary.

hot/cold pad 1x1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary last updated 5/12/14; ODG-TWC Knee and Leg Procedure Summary last updated 6/5/14.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Cold/heat packs.

Decision rationale: The California MTUS does not address the issue specifically; however, the Official Disability Guidelines state that cold/heat packs are recommended as an option for acute pain. At home, local applications of cold packs in the first few days of acute complaint; thereafter, applications of heat packs or cold packs are recommended. In this case, the patient complained of chronic back pain. Physical findings do not provide evidence of acute exacerbations. Cold/heat packs are recommended as option for acute pain. The medical necessity has not been established. Therefore, the request is not medically necessary.

Assy strap: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Medical Policy Durable Medical Equipment CG-DME-10.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Durable Medical Equipment (DME).

Decision rationale: The California MTUS does not address this topic; however, the Official Disability Guidelines state that durable medical equipment (DME) is recommended generally if there is a medical need and if the device meets the Medicare's definition of DME, i.e. it can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. In this case, there was no discussion as to why an assy strap is needed. The medical necessity for an assy strap has not been established. Therefore, the request is not medically necessary.