

<b>Case Number:</b>	CM14-0104445		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	03/01/2006
<b>Decision Date:</b>	10/23/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2014

### 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 Internal Medicine, has a subspecialty in Nephrology 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 55-year-old male who has submitted a claim bilateral L5 radiculopathy, musculoligamentous sprain of the lumbar spine, lumbar radiculitis, chronic low back pain, and right knee pain associated with an industrial injury date of 3/1/2006. Medical records from 12/24/2013 up to 8/15/2014 were reviewed showing neck pain with radiations down his bilateral upper extremities. He also complained of low back pain with radiations down his bilateral lower extremities. Pain was rated at 9/10 with medications and 10/10 without medications. Patient has difficulty with ambulation, hand function, and sleep. It was noted on PR dated 7/7/2014 that the TENS unit and infrared therapy were request for use on the lumbar spine and right knee to help decrease pain and spasm, and improve the patient's range of motion. Lumbar examination noted spasm in the bilateral paraspinous musculature. There was tenderness over the spinal vertebral area L4-S1 levels with limited ROM secondary to pain. Sensory exam revealed decreased sensitivity to touch along the L5-S1 dermatomes in the left lower extremity. Seated SLR was positive at 70 degrees bilaterally. Tenderness was noted over the right knee with limited ROM secondary to pain. Treatment to date has included right knee arthroscopy, arthroplasty, LESI, physical therapy, acupuncture, and medications. Utilization review from 6/24/2014 denied the request for 1 [REDACTED], FIR heating pad and 1 [REDACTED] stimulator unit, 30 days supplies, conductive garment between 6/2/14 and 8/16/14. Regarding the [REDACTED] heating pad, this is not recommended over other heat therapies. Regarding the [REDACTED], the patient had undergone medication management with no evidence of failure. Furthermore, the provider did not include specific short and long-term goals of treatment. Instead he included much generalized outcome goals which were non-specific.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 [REDACTED], FIR heating pad: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 338. Decision based on Non-MTUS Citation Official Disability Guidelines

**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, Infrared therapy (IR)

**Decision rationale:** The CA MTUS does not address this topic specifically. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Low Back chapter, Cold/heat packs was used instead. The Official Disability Guidelines state that infrared therapy is not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care (exercise). In this case, the patient complained of neck, low back, and knee pain. Pain was rated at 9/10 with medications and 10/10 without medications. Patient has difficulty with ambulation, hand function, and sleep. However, there was no documentation that the patient was participating in a rehabilitation program. The guidelines recommend IR therapy as adjunct to exercise. Moreover, infrared therapy is not recommended over other heat therapies. Therefore, the request for 1 [REDACTED] FIR heating pad is not medically necessary.

**1 [REDACTED] stimulator unit, 30 days supplies, conductive garment between 6/2/14 and 8/16/14: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation Page(s): 117-118.

**Decision rationale:** As stated on pages 117-118 of CA MTUS Chronic Pain Medical Treatment Guidelines, H-wave stimulation (HWT) is not recommended as an isolated intervention, but a trial may be considered as a non-invasive conservative option for chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration. There is no evidence that H-Wave is more effective as an initial treatment when compared to TENS for analgesic effects. In this case, the patient complained of neck, low back, and knee pain. Pain was rated at 9/10 with medications and 10/10 without medications. Patient has difficulty with ambulation, hand function, and sleep. It was noted on PR dated 7/7/2014 that the TENS unit was requested to help decrease pain and spasm, and improve the patient's range of motion. However, there is no documentation of specific short-term and long-term treatment plans and goals from the physician with the use of H-wave. There is no evidence that the request will be used as an

adjunct to a program of evidence-based functional restoration. Moreover, the request failed to specify if the device is for rental or purchase. Therefore, the request for [REDACTED] stimulator unit is not medically necessary.