

Case Number:	CM14-0109116		
Date Assigned:	08/04/2014	Date of Injury:	05/07/2012
Decision Date:	09/10/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	07/14/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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 59-year-old male with an injury date of 05/07/2012. The patient complains of back pain rated 4/10. Upon physical examination, he has tenderness with muscle spasms over the dorsal and lumbar paraspinal muscles bilaterally and painful/restricted range of motion of the dorsum of the lumbar spine. The patient's diagnoses include dorsal sprain/strain and lumbar sprain/strain. The requests at issue are the following: a hot/cold unit; a pad/wrap; a lumbosacral orthosis (LSO) brace; an interferential (IF) stimulator unit; a ten-pack of electrodes; ten batteries; and one set-up and delivery. The utilization review (UR) determination being challenged is dated 07/08/2014. Treatment reports were provided from 04/03/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/Cold Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (http://www.odg-twc.com/odgtwc/low_back.htm#TreatmentPlanning).

Decision rationale: According to the 05/15/2014 report, the patient presents with back pain. The request is for a hot/cold unit. In regards to cold therapy, ODG Guidelines recommends it for acute back pain only, while for chronic pain, continuous heat therapy is recommended. ACOEM also recommends the at-home application of cold/heat. The current request is for a hot/cold unit, but does not describe what this unit actually is. While simple hot pads or cold packs may be a cost-effective option, more sophisticated units are not. Therefore, this request is not recommended as medically necessary.

Pad/Wrap: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (http://www.odg-twc.com/odgtwc/low_back.htm#TreatmentPlanning).

Decision rationale: According to the 05/15/2014 report, the patient presents with back pain. The utilization review letter states that the pad/wrap was to be used with the requested hot/cold unit. Since the request for a hot/cold unit is denied, the request for the pad/wrap is also denied.

LSO Back Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (http://www.odg-twc.com/odgtwc/low_back.htm#Lumbar supports).

Decision rationale: According to the 05/15/2014 report, the patient presents with back pain. The request is for an LSO brace. ACOEM Guidelines page 301 states, "Lumbar support has not been shown to have any lasting benefit beyond the acute phase of symptom relief". Page 9 of ACOEM Guidelines also states, "The use of back belts as lumbar support should be avoided because they have been shown to have little or no benefit, therefore, providing only a false sense of security". The Official Disability Guidelines also state that it is not recommended for prevention or for treatment. It is an option for fracture, spondylolisthesis, documented instability, and nonspecific low back pain (very low quality evidence). Given the lack of ACOEM and ODG Guideline support for the use of lumbar bracing, this request is not recommended as medically necessary.

IF Stimulator Unit: 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 (ICS) Page(s): 118-120.

Decision rationale: Based on the 05/15/2014 report, the patient presents with back pain. The request is for the purchase of an IF stimulator unit to increase range of motion, minimize swelling, increase circulation, reduce pain, and re-educate muscles. The report with the request was not provided. MTUS Chronic Pain guidelines, pages 118-120, state that interferential current stimulation is not recommended as an isolated intervention. If indicated, however, MTUS recommends trying the unit for one month before a home unit is provided. There is no indication that the patient has had a one-month trial of the IF stimulator. Given that the request is for IF unit without a specific request for a one-month trial, the request is not medically necessary or appropriate.

10 Pack of electrodes: Upheld

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

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

Decision rationale: According to the 05/15/2014 report, the patient presents with back pain. The request is for a 10-pack of electrodes, presumably for the IF stimulator unit. The report with the request was not provided. MTUS guidelines state that interferential current stimulation is not recommended as an isolated intervention. They recommend trying the unit for one month before a home unit is provided, and there is no indication that the patient has had a one-month trial of the IF unit. Since the request for the IF stimulator unit was not medically necessary, the request for a 10-pack of electrodes is not medically necessary.

10 Batteries: Upheld

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

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

Decision rationale: Based on the 05/15/2014 report, the patient complains of back pain. The request is for 10 batteries, presumably for the IF stimulator unit. As mentioned earlier, the IF stimulator unit was not found to be medically necessary. Therefore, the request for 10 batteries is not medically necessary.

1 set up and delivery: Upheld

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

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

Decision rationale: In regards to an IF unit, MTUS Guidelines state that it is not recommended as an isolated intervention and recommend trying the unit for one month before a home unit is provided. There is no indication that the patient has had a one-month trial of the IF stimulator. Since the request for the IF stimulator unit was not found to be medically necessary, there is no use for a set-up and delivery.