MAXIMUS Federal Services

Case Number:	CM14-0109814		
Date Assigned:	08/01/2014	Date of Injury:	07/12/2002
Decision Date:	09/03/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/15/2014

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 and Rehabilitation, has a subspecialty in Pain Management, 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 female patient with a date of injury of July 12, 2002. A progress note dated June 17, 2014 identifies subjective complaints of lower back pain rated at a 7/10 with associated soreness and numbness, and left leg numbness. Physical examination identifies a six-inch surgical scar, tenderness to the lumbar region with paraspinal spasms left greater than right, limited lumbar range of motion, hypoesthesia to the left L 3 to S 1 dermatome, tenderness to the thoracic region, and left greater than right thoracic paraspinal spasm. Diagnoses include status post lumbar surgery, myospasm, and thoracic sprain/strain. The treatment plan recommends an MRI of the lumbar spine, an x-ray of the thoracic spine, an x-ray of the lumbar spine, chiropractic therapy three times per week for four weeks, topical compound creams, a functional capacity evaluation, you're in toxicology screening, neuro consult, IF unit, and motorized cold therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines.

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

Decision rationale: Regarding the request for an interferential unit, the California MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement. In light of the above issues, the currently requested interferential unit is not medically necessary.

Motorized cold therapy unit: Upheld

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

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), Low Back Chapter, Cold/Heat Packs.

Decision rationale: Regarding the request for a cold therapy unit, the California MTUS and Official Disability Guidelines (ODG) do not specifically address the issue for the low back, although the ODG supports cold therapy units for up to 7 days after surgery for some other body parts. For the back, the California MTUS/ACOEM and ODG recommend the use of cold packs for acute complaints. Within the documentation available for review, there is no documentation of a rationale for the use of a formal cold therapy unit rather than the application of simple cold packs at home during, and the patient is well over 7 days of the postoperative period. In the absence of such documentation, the currently requested cold therapy unit is not medically necessary.