

Case Number:	CM14-0109981		
Date Assigned:	08/01/2014	Date of Injury:	06/01/2012
Decision Date:	09/24/2014	UR Denial Date:	06/27/2014
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 Anesthesiology, 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:

The patient is a 50-year-old male who has submitted a claim for cervicalgia, cervicobrachial syndrome and other affectations of the shoulder associated with an industrial injury date of June 1, 2012. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of recurrent headaches, and pain in the neck, bilateral shoulders and low back. Physical examination of the cervical spine revealed tenderness of the paravertebral muscles and trapezius and slightly decreased ROMs. There was tenderness of the periscapular area. Examination of the lumbar spine revealed no gross deformity, normal ROMs and absence of tenderness. An x-ray of the right shoulder and MRI of the hip revealed no abnormal findings except for minimal degenerative changes of the glenohumeral joint. An MRI of the right shoulder revealed no rotator cuff except for any osteoarthritic changes in the right glenohumeral joint. Treatment to date has included medications, acupuncture and home exercises. Utilization review from June 27, 2014 denied the request for Multi Stimulation Unit plus supplies x5 month rental and Hot/cold Unit. The request for Multi Stimulation Unit was denied because the criteria for the use of TENS was not satisfied; there was no evidence of diminished effectiveness of medication or side effects and there was no documented failure or attempts at PT or exercise.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multi Stimulation Unit plus supplies x5 month rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy; Transcutaneous Electrical Nerve Stimulation Page(s): 114-116.

Decision rationale: Page 114 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that transcutaneous electrotherapy includes TENS, interferential current stimulation, microcurrent electrical stimulation, neuromuscular electrical stimulation, RS-4i sequential stimulator, electroceutical therapy, and sympathetic therapy. TENS units are not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. Criteria for the use of TENS unit include chronic intractable pain - pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, and a treatment plan including the specific short- and long-term goals of treatment with the TENS unit. In this case, the patient had been experiencing pain for more than three months. There was evidence that other pain modalities such as medication, acupuncture and home exercises were tried; however there was no documentation regarding the outcomes of these modalities. Moreover, it is unclear why a Multi-Stimulation unit should be recommended in this case. There was no treatment plan that includes the specific short- and long-term goals of treatment. Finally, the request of rental for five months exceed the recommended one-month trial. Therefore, the request for Multi Stimulation Unit plus supplies x5 month rental is not medically necessary.

Hot/cold Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

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

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Aetna was used instead. Aetna considers the use of the Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System (an iceless cold compression device), the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source. In this case, there was no discussion as to why standard ice bags/packs will be insufficient to provide symptomatic relief. The request likewise failed to specify the body part to be treated or whether the device was for purchase or rental. Therefore, the request for Hot/cold Unit is not medically necessary.