

<b>Case Number:</b>	CM14-0016213		
<b>Date Assigned:</b>	04/14/2014	<b>Date of Injury:</b>	06/06/2003
<b>Decision Date:</b>	05/28/2014	<b>UR Denial Date:</b>	01/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2014

### 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 [REDACTED] employee who has filed a claim for cervical pain and thoracic/lumbosacral neuritis/radiculitis associated with an industrial injury of June 06, 2003. Thus far, the patient has been treated with cervical steroid injection, and medications that include TENS, Ambien, NSAIDs, opioids, fentanyl patches, and Lyrica. Patient had multiple surgeries of the foot and exploration of the right knee with incision and drainage on May 10, 2013. In a utilization review report of January 14, 2014, the claims administrator denied a retrospective request for interferential unit purchase with 18 pairs of electrodes as there is no documentation of significant post-operative deficits, and motorized cold therapy unit purchase as there is no evidence to support purchase of cold therapy unit. Latest progress note documented is from June 2013. Lumbar MRI dated September 15, 2011 showed multilevel degenerative spondylosis with varying degrees of central canal and neural foraminal narrowing.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **RETROSPECTIVE REQUEST FOR INTERFERENTIAL UNIT PURCHASE WITH ELECTRODES 18 PAIRS PURCHASE, DOS 5/10/13: Upheld**

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

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that a one-month trial may be appropriate when pain is ineffectively controlled due to diminished effectiveness of medications; or pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or unresponsive to conservative measures. In this case, the patient underwent right knee surgery but there is no documentation regarding decreased effect of medications or postoperative limitations that would preclude patient from participating in physical treatment modalities. Also, there is no rationale as to why purchase of the IF unit is necessary. Therefore, the retrospective request for interferential unit with electrodes purchase was not medically necessary and appropriate.

**RETROSPECTIVE REQUEST FOR MOTORIZED COLD THERAPY UNIT,  
PURCHASE, DOS 5/10/13: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Knee and Leg.

**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 Continuous Flow Cryotherapy.

**Decision rationale:** The California MTUS Guidelines does not specifically address this issue. The Official Disability Guidelines (ODG) states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In this case, although cryotherapy may be necessary in this patient, there is no rationale as to why purchase of the unit is necessary as guidelines only recommend 7-day use. Therefore, the retrospective request for motorized cold therapy unit purchase was not medically necessary and appropriate.