

Case Number:	CM14-0017061		
Date Assigned:	04/14/2014	Date of Injury:	06/10/2009
Decision Date:	05/30/2014	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	02/11/2014

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 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 injured worker reported an injury on 06/10/2009. The mechanism of injury was the injured worker was lifting a trashcan to dump out the trash when it fell and struck her in the knee and injured her low back. The prior treatments included physical therapy, epidural injections, and a spinal cord stimulator, as well as medications. The documentation of 12/24/2013 revealed the injured worker had a severe limp because due to pain in the right ankle, right knee, and back. The injured worker had decreased range of motion. The diagnoses included complex regional pain syndrome in the right lower extremity, right knee medial meniscal tear, right ankle and foot regional pain syndrome, lumbar pain stimulator in place, lumbar secondary to abnormal gait and pain, stimulator surgery, right shoulder overuse with impingement and subacromial bursitis from cane use, right wrist and hand pain secondary to overuse of cane, anxiety/depression, insomnia, and morbid obesity. Treatment included Tylenol No. 4, Xanax, Functional Capacity Evaluation, and a urine drug screen. The submitted request per the Application of Independent Medical Review was for an X-Force stimulator with conductive garments and Solar Care infrared heating pad purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

**X-FORCE STIMULATOR UNIT PURCHASE PLUS 3 MONTHS SUPPLIES,
CONDUCTIVE GARMENT (X2): Upheld**

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 115-116.

Decision rationale: California MTUS recommends a one month trial of a TENS unit as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least 3 months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. There was lack of documentation indicating the injured worker had trialed a TENS unit for 1 month and if so, there was lack of documentation indicating the objective functional benefit received from the unit. A purchase would not be supported without a trial of the unit. The California MTUS Guidelines go on to indicate that form-fitting TENS devices are considered medically necessary when there is documentation there is such a large area that requires stimulation that a conventional system cannot accommodate the treatment and that the patient has medical conditions that prevent the use of a traditional system. The clinical documentation submitted for review failed to provide DWC Form RFA and a PR-2 to support the requested service. Additionally, there was lack of documentation indicating rationale for an X-Force purchase with 3 months supplies and conductive garment. Given the above, the request for X-Force stimulator unit purchase, plus 3 months supplies, conductive garment x2 is not medically necessary and appropriate.

2. SOLAR CARE INFRARED HEATING PAD PURCHASE: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205, Chronic Pain Treatment Guidelines Low-Level Laser Therapy (LLLT) Page(s): 57. Decision based on Non-MTUS Citation Low Back chapter, Infrared.

Decision rationale: ACOEM Guidelines indicate that local application of cold during the first few days of an acute complaint for the shoulder is appropriate. Thereafter, heat application is appropriate. ACOEM Guidelines however, do not specifically address infrared therapy. California MTUS guidelines address Low-Level Laser Therapy (LLLT); however, they do not address infrared therapy specifically. As such, secondary guidelines were sought. Official Disability Guidelines do not recommend infrared therapy over other heat therapies. The clinical documentation submitted for review failed to indicate the injured worker had necessity for infrared therapy. There was a lack of documentation indicating the injured worker could not use a heat pack versus a heating pad. Given the above and the lack of documentation, the request for Solar Care infrared heating pad purchase is not medically necessary and appropriate.