

Case Number:	CM14-0018670		
Date Assigned:	04/18/2014	Date of Injury:	12/28/2012
Decision Date:	07/02/2014	UR Denial Date:	02/05/2014
Priority:	Standard	Application Received:	02/13/2014

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 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 is a 46 year old male who reported an injury to his lower back and right side of his body secondary to being pulled by a door on 12/28/2012. The Electromyography study of the lower extremity dated 01/20/2014 revealed findings suggestive of bilateral chronic active L5 radiculopathy, right side greater than the left side. The clinical note dated 08/11/2013 indicated the injured worker had diagnoses including lumbosacral strain, lumbosacral and wrist pain, lumbar spine spondylosis, and strain wrist radiocarpal point ligament. The injured worker reported low back pain that he rated 7/10 and pain to the right wrist that he rated 3/10. The lumbar spine range of motion findings were flexion to 70 degrees without pain, extension to 30 degrees with mild pain, and bilateral lateral bending to 30 degrees with mild pain bilaterally. The physical therapy report dated 07/11//2013 reported average pain rated 6/10 and the injured worker reported physical therapy was helping his condition improve. The injured worker's medication regimen included prilosec, motrin and vicoprofen. The request for authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

INTERFERENTIAL STIMULATOR (IF UNIT) AND ONE YEAR OF SUPPLIES:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION (ICS) Page(s): 118.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines indicated that interferential current stimulation is not recommended as an isolated intervention. There is no evidence of effectiveness except in conjunction with recommended treatments such as returning to work, exercise and medications and limited evidence on those improvements recommended treatments alone. It is possibly appropriate for the following conditions, (if it has proven to be effective as directed or applied by the physician or a provider, licensed to provide physical medicine: 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 treatments; or unresponsive to conservative measures. The injured worker injured his lower back and right side of his body. There is inadequate documentation as to the amount of physical therapy sessions the injured worker has completed as well as the efficacy of prior therapy. It was unclear if the interferential unit would be used as an adjunct to an active treatment modality. Therefore, per the California Chronic Pain Medical Treatment Guidelines, the request for the interferential stimulator and one year of supplies is not medically necessary.

THERMACOOLER SYSTEM X (8) WEEKS WITH WRAP: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 155.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM) 2ND EDITION (2004), HOT AND COLD THERAPY, 335-342.

Decision rationale: The American College of Occupational and Environmental Medicine (ACOEM) indicates home application of hot and cold is as productive as those performed by the providers. Per the American College of Occupational and Environmental Medicine (ACOEM), self applications of heat and cold therapy is recommended for acute or chronic low back pain. The Official Disability Guidelines recommend cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. While hot/cold therapies may benefit the patient, it was noted traditional at home applications such as ice packs and heating pads are as productive as those performed by providers. The injured worker was diagnosed with lumbosacral strain, lumbosacra and wrist pain, lumbar spine spondylosis, and strain wrist radiocarpal point ligament. It did not appear the injured worker recently underwent surgical intervention or was scheduled for surgical intervention in the near future. Therefore, per the guidelines, the request for thermacooler system x (8) weeks with wrap is not medically necessary.

