

Case Number:	CM14-0132572		
Date Assigned:	08/22/2014	Date of Injury:	05/16/2007
Decision Date:	09/24/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/19/2014

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 Tennessee. 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 53-year-old female with a 5/16/07 date of injury. The mechanism of injury was a work related fall. According to a progress report dated 8/7/14, the patient complained of a lot of pain in his low back rated 8/10. He said that the pain felt sharp and at times feels very numb. The pain radiated down to his bilateral knees and legs. Medications and compound medication creams have been helping. Objective findings: tenderness to bilateral knees, limited range of motion (ROM) of knees, tenderness to lumbar spine, limited ROM of lumbar spine, tenderness to cervical spine. Diagnostic impression: bilateral knees internal derangement, status post lumbar surgery, sciatica, cervical radiculitis. Treatment to date: medication management, activity modification, aquatic therapy. A UR decision dated 8/8/14 denied the requests for interferential unit purchase, monthly supplies for interferential unit, cold therapy unit, and hot/cold pad. Regarding interferential unit and supplies, the superiority of an interferential unit over TENS has not been demonstrated. Regarding cold therapy unit and hot/cold pad, routine use of cryotherapy in health care provider offices or home use of a high-tech device for the treatment of low back pain is not recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interspec Interferential Unit 2 for purchase qty 1: 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 Chronic Pain Treatment Guidelines Page(s): 118-120.

Decision rationale: 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. There is no documentation that the patient has failed conservative treatment modalities. It is noted that her pain is improving with medication use. In addition, there is no documentation in the reports reviewed that she has had a trial of physical therapy. The patient has stated that aquatic therapy has helped her previously. Therefore, the request for Interspec Interferential Unit 2 for purchase qty 1 was not medically necessary.

Interferential unit supplies, life time supply: 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 Chronic Pain Treatment Guidelines Page(s): 118-120.

Decision rationale: 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. Because the request for an interferential unit purchase was not authorized, this associated request cannot be substantiated. Therefore, the request for Interferential unit supplies, life time supply was not medically necessary.

Cold therapy unit, for rental or purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 160-161. Decision based on Non-MTUS Citation Official Disability Guidelines.

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: California Medical Treatment Utilization Schedule (MTUS) and Official Disability Guidelines (ODG) do not address this issue. 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. There is no documentation that the patient has tried traditional cold/hot packs for her pain. A specific rationale identifying why a cold therapy unit is required in this patient despite lack of guideline support was not provided. Therefore, the request for Cold therapy unit, for rental or purchase was not medically necessary.

Hot and cold pad qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 160-161.

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: California Medical Treatment Utilization Schedule (MTUS) and Official Disability Guidelines (ODG) do not address this issue. 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. Because the request for cold therapy unit was not authorized, this associated request cannot be substantiated. Therefore, the request for Hot and cold pad qty 1 was not medically necessary.