

<b>Case Number:</b>	CM14-0155392		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	09/16/2010
<b>Decision Date:</b>	11/24/2014	<b>UR Denial Date:</b>	08/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2014

### 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 Orthopedic Surgery and is licensed to practice in New York. 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 48-year-old male. The patient has chronic pain. He has an anxiety disorder. He's diagnosed with cervical mild strain and mild lumbar strain. MRI shows left paracentral disc protrusion slightly impinging on the left S1 nerve root. Physical examination describes L5 and S1 radiculopathy on the left greater than the right. The patient has chronic neck and back pain. He had epidural injections which gave him significant relief. EMG studies do not document radiculopathy. The patient is scheduled for another epidural injection. At issue is whether hot cold unit therapy and IF unit are medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hot/Cold therapy unit:** 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 12 Low Back Complaints Page(s): 307, 322, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back Chapter.

**Decision rationale:** Guidelines do not support the use of hot cold therapy unit for chronic back pain. There is no literature support improved outcomes using hot cold therapy for chronic back

pain. This patient has degenerative low back pain. Heat cold therapy unit is not likely to improve his functional outcome. Guidelines do not support the use of hot cold therapy for chronic low back pain. The request is not medically necessary.

**IF unit:** Upheld

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

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

**Decision rationale:** This patient does not meet criteria for IF (interferential) unit for chronic low back pain. Specifically the medical records do not document an adequate trial and failure of conservative measures to include physical therapy for low back pain that has recently been performed. The medical records do not clearly document exactly what conservative measures have been tried and the extent of improvement from those conservative measures. The patient has had chronic back pain for over a year. It is unclear exactly what conservative measures have been tried. A trial and failure of physical therapy must be documented and conservative measures must be adequately attempted. IF unit for low back pain is not medically necessary at this time.

**Knee walker:** 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 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back Chapter

**Decision rationale:** The medical records do not document that the patient has a significant problem with ambulation from chronic low back pain. There is not evaluation from physical therapist that documents the need for front wheel walker. Criteria for front wheel walker not met. The request is not medically necessary.

**Shower Boot:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** This patient does not meet establish criteria for lumbar surgery. There is no clear correlation between physical exam findings and imaging studies showing specific radiculopathy and specifically pressure nerve roots. Since surgery is not medically necessary, then all other associated items are not needed. The medical records do not substantiate the need for shower boot. The request is not medically necessary.

