

Case Number:	CM14-0156868		
Date Assigned:	09/26/2014	Date of Injury:	03/14/2012
Decision Date:	10/27/2014	UR Denial Date:	09/08/2014
Priority:	Standard	Application Received:	09/25/2014

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 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:

This 29-year-old male machine operator sustained an industrial injury on 3/14/12. He reported an onset of low back and right groin pain stacking boxes on a pallet. The patient underwent an umbilical hernia repair on 5/21/14 and right inguinal hernia repair on 6/11/14. The 8/26/14 durable medical equipment prescription form for the purchase of an interferential (IF) unit with supplies and ARS Hot/Cold therapy unit documented the indication for use as limited range of motion and body part as the lumbar spine. This durable medical equipment was intended to increase/preserve range of motion, reduce pain and swelling, and increase circulation. The 8/29/14 treating physician report noted low back pain with full range of motion and strength. The treatment plan included a hot/cold compression unit and interferential unit with supplies for the lumbar area. The 9/8/14 utilization review denied the request for the hot/cold compression unit as there was inadequate clinical and guideline support for a cold/heat unit over hot/cold packs. The request for an interferential unit was denied as there was no guideline support for use.

IMR ISSUES, DECISIONS AND RATIONALES

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

ARS-Hot/Cold Compression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder and Knee

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

Decision rationale: The California MTUS guidelines state that the routine use of high-tech devices for hot or cold therapy is not recommended in the treatment of lower back pain. Guidelines support the use of hot or cold packs for patients with low back complaints. Guideline criteria have not been met. There is no compelling reason submitted to support the medical necessity of a cold/hot therapy unit over simple hot/cold packs. Therefore, this request is not medically necessary.

ARS-Pad/Wrap (purchase): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: As the hot/cold unit request is not supported, this request is not medically necessary.

Interferential Stimulator: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): , page(s) 114-121.

Decision rationale: The California MTUS guidelines do not recommend interferential current (IFC) stimulation as an isolated intervention. Guidelines indicate that IFC is possibly appropriate if pain is ineffectively control due to diminished effectiveness of medications or due to medication side effects, there is a history of substance abuse, significant post-operative pain limits ability to perform exercise/physical therapy treatment, or the patient is unresponsive to conservative measures. If those criteria are met, then a one-month trial may be appropriate to study effects and functional benefit. Guideline criteria have not been met. There is no evidence that the patient has failed to benefit from medications or conservative treatment. There is no indication that post-operative pain prohibits participation in exercise or physical therapy. Additionally, the request for purchase of an IFC unit exceeds guidelines recommendations. Therefore, this request is not medically necessary.

10 Electrodes: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines .Transcutaneous electrotherapy, Page(s): s) 114-121.

Decision rationale: As the interferential unit request is not supported, this request is not medically necessary

10 Batteries (purchase): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Page(s): page(s) 114-121.

Decision rationale: As the interferential unit request is not supported, this request is not medically necessary.