

<b>Case Number:</b>	CM14-0174880		
<b>Date Assigned:</b>	10/28/2014	<b>Date of Injury:</b>	09/27/2012
<b>Decision Date:</b>	12/04/2014	<b>UR Denial Date:</b>	09/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/22/2014

### 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, has a subspecialty in Pain Management 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 is a male patient with the date of injury of September 27, 2012. A Utilization Review was performed on September 26, 2013 and recommended non-certification of home interferential unit (orthoStim4) and moist heat pad (Thermophon). A Doctor's First Report dated September 8, 2014 identifies Subjective Complaints of right shoulder pain, neck pain, low back pain, right hip pain, frequent headaches, emotional complaints, insomnia, and gastrointestinal upset/heartburn. Objective Findings identify tenderness to palpation with spasm/hypertonicity is present over the suboccipital region, paraspinal musculature and upper trapezius muscles, right side greater than left and decreased cervical spine range of motion. Tenderness to palpation with muscle guarding is present over the subacromial region extending over the anterior capsule, acromioclavicular joint and periscapular musculature. There is the presence of trapezial myofascial trigger points. Impingement test is positive. Tenderness to palpation with spasm hypertonicity is present over the paraspinal musculature extending over the lumbosacral junction and decreased low back range of motion. Tenderness to palpation with muscle guarding is present over the anterior joint and gluteal musculature. Crepitus is present with passive ranging. Patrick Fabere's test is positive for increased right hip joint pain. Diagnoses identify cervical/trapezial musculoligamentous sprain/strain, lumbar spine musculoligamentous sprain/strain, and right hip sprain with labral tear, post-traumatic headaches, emotional complaints, insomnia, and heartburn /gastrointestinal upset. Treatment Plan identifies request authorization for home interferential unit (OrthoStim 4) and moist heat pad (Thermophore).

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Home Interferential Unit (OrthoStim 4):**

**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): 300, Chronic Pain Treatment Guidelines Page(s): 118-120 of 127.

**Decision rationale:** Regarding the request for Home Interferential Unit (Orthostim 4), CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. In light of the above issues, the currently requested Home Interferential Unit (Orthostim 4) is not medically necessary.

#### **Moist Heat Pad (Thermophon): Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter Cold/Heat Packs

**Decision rationale:** Regarding the request for Moist Heat Pad (Thermophon), Occupational Medicine Practice Guidelines state that various modalities such as heating have insufficient testing to determine their effectiveness, but they may have some value in the short term if used in conjunction with the program of functional restoration. ODG states that heat/cold packs are recommended as an option for acute pain. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation of acute pain and what program of functional restoration the patient is currently participating in which would be used alongside the currently requested heat pad. In light of the above issues, the currently requested and Moist Heat Pad (Thermophon) is not medically necessary.