

<b>Case Number:</b>	CM14-0029387		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	10/28/2013
<b>Decision Date:</b>	07/24/2014	<b>UR Denial Date:</b>	02/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/07/2014

### 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 & 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 patient with a date of injury of 10/28/13. A utilization review determination dated 2/24/14 recommends non-certification of a heat pad, interferential stimulator 1-month rental, and additional 3-month rental if effective. A 2/21/14 medical report identifies low back pain with numbness and tingling into the legs. On exam, there is tenderness, limited ROM, decreased patchy sensation in the RLE. Recommendations include PT, OrthoStim4, and Thermophore.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Heatpad (purchase):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Table 12-8. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Cold/heat packs.

**Decision rationale:** California MTUS supports at-home applications of local heat or cold to low back as an option in the management of low back complaints, although no recommendations are made with regard to the devices used for these applications. ODG notes that cold/heat packs are recommended as an option for acute pain (at-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs). Within the

documentation available for review, there is no clear rationale for the use of a specialized heating pad rather than simple heat packs for the management of the patient's cited conditions. In the absence of such documentation, the currently requested Heatpad (purchase) is not medically necessary.

**Interferential stimulator with supplies 1 month rental with supplies (batteries, electrodes 4 packs, power pack #12, adhesive remover towel mint #16, leadwire): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

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

**Decision rationale:** The medical documentation notes that the device is an OrthoStim4 unit, which contains high volt pulsed stimulation, neuromuscular electrical stimulation, and pulsed direct current stimulation in addition to interferential stimulation. California MTUS notes that galvanic stimulation (high voltage, pulsed stimulation) is not recommended and considered investigational for all indications. NMES is not recommended, as it is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. Interferential stimulation is possibly appropriate for certain conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine. Within the documentation available for review, there is no documentation that the abovementioned criteria for interferential stimulation have been met and no rationale for the use of the other electrical stimulation modalities despite the recommendations of the CA MTUS. In light of the above issues, the currently requested interferential stimulator is not medically necessary.

**Additional 3 months of rental if effective:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary item is not medically necessary, none of the associated items are medically necessary.