

Case Number:	CM14-0030656		
Date Assigned:	06/20/2014	Date of Injury:	05/19/2010
Decision Date:	07/17/2014	UR Denial Date:	02/26/2014
Priority:	Standard	Application Received:	03/10/2014

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 and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 63-year-old female with a reported injury on 05/19/2010. The mechanism of injury was not provided with in clinical documentation. The clinical note dated 04/09/2014 reported that the injured worker complained of lumbar spine, left shoulder, left knee pain. The physical examination was not provided within the clinical note. The injured worker's medication list included Norco, Norflex, and Axid. The injured worker's diagnoses included pain in shoulder joint; lumbago; pain in lower leg joint; and degenerative lumbar-lumbosacral region. The provider requested a neuromuscular stimulator unit and a motorized hot/cold therapy unit, the rationales were not provided within the clinical documentation. The Request for Authorization was submitted on 03/06/2014. The injured worker's previous treatments were not provided within the clinical notes.

IMR ISSUES, DECISIONS AND RATIONALES

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

NEUROMUSCULAR STIM UNIT E0745 WITH ELECTODES 18 PAIR/UNITS A4556 FOR PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: The injured worker complained of low back, left shoulder, and left knee pain. The requesting physician did not provide rationale for neuromuscular stimulator unit. The California MTUS guidelines do not recommend the use of neuromuscular electrical stimulation (NMES devices). NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. There is a lack of clinical documentation indicating the requesting provider's rationale for a NMES device. Moreover, a neuromuscular electrical stimulation device is used in rehabilitation programs following a cerebrovascular accident or stroke. The guidelines do not recommend an NMES for chronic pain. There is a lack of clinical information provided documenting the efficacy of the NMES as evidenced by decreased pain and significant objective functional improvements. Furthermore, the requesting provider did not specify the location of application of the neuromuscular stimulating unit being requested. Given the information provided, there is not sufficient evidence to determine appropriateness to warrant medical necessity. In addition, a neuromuscular electrical stimulation device is not recommended per the guidelines; as such, the request is not medically necessary.

MOTORIZED HOT/COLD THERAPY UNIT PURCHASE E0217 FOR PURCHASE:

Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ACOEM Practice Guidelines 3rd Ed., Chapter 12: Low Back Disorders Chapter (update to Chapter 12), pages 155 and Official Disability Guidelines (ODG), Low Back Chapter - Heat Therapy.

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, Cold/Heat Packs.

Decision rationale: The injured worker complained of low back, left shoulder, and left knee pain. The treating physician's rationale for a motorized hot cold therapy unit was not provided within the clinical notes. The Official Disability Guidelines recommend cold/heat packs as an option for acute pain and at-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. There is a lack of clinical information provided documenting the efficacy of a motorized hot/cold therapy unit as evidenced by decreased pain and significant objective functional improvements. There is a lack of clinical information provided indicating a rationale for the motorized hot/cold therapy unit. Furthermore, there is a lack of clinical information provided to determine the reason the injured worker requires a high tech cryotherapy unit. Given the information provided, there is insufficient evidence to determine the appropriateness to warrant medical necessity; therefore, the request is not medically necessary.

