

Case Number:	CM14-0091866		
Date Assigned:	07/25/2014	Date of Injury:	02/18/2014
Decision Date:	11/18/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	06/17/2014

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 Family Medicine, has a subspecialty in family Practice and is licensed to practice in Ohio. 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 51-year-old female with cumulative dates of injury between June 10, 2013 and May 6, 2014. She complains of neck pain, upper back pain, bilateral hand pain, lower back pain, and anxiety. The physical exam has revealed tenderness to palpation along the cervical, thoracic, and lumbar spine, spasm of the trapezii, cervical, and lumbar paraspinal musculature and tenderness of the wrists and hands. There is diminished lumbar range of motion. On May 22, 2014 the injured worker was simultaneously prescribed and interferential unit, a motorized cold therapy unit, oral pain medication and topical analgesics. The diagnoses include anxiety, and sprains/strains of the cervical, thoracic, and lumbar spine and bilateral hands. At issue are a motorized cold therapy unit and supplies for an interferential unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interspec IF II supplies: Upheld

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

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

Decision rationale: While Interferential Current Stimulation (ICS) is not recommended as an isolated intervention, the patient selection criteria if interferential stimulation is to be used anyway are: Pain is ineffectively controlled due to diminished effectiveness of medications; Pain is ineffectively controlled with medications due to side effects; History of substance abuse; Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. In this instance, it would appear that the treating physician prescribed medications, cold therapy, and Interferential Current Stimulation (ICS) simultaneously on 5-22-2014. As the injury was reported 5/6/2014, there could not have been an adequate time period to assess the potential effectiveness of medication if it was indeed prescribed at the time of injury. Therefore, the medical necessity of Interferential Current Stimulation (ICS) was not initially established and consequently the accompanying supplies (Interspec IF II) are not medically necessary.

Cold therapy unit, hot/cold pad: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 12 Low Back Complaints Page(s): 44, 299. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Heat Therapy and cold/heat therapy

Decision rationale: Musculoskeletal symptoms can be managed with a combination of heat or cold therapy, short-term pharmacotherapy (oral medication), a short period of inactivity, specific recommendations regarding employment and recreational activities, and judicious mobilization and resumption of activity, even before the patient is pain-free. The American College of Occupational and Environmental Medicine guidelines do suggest cold therapy for the first few days following a back injury followed by alternating heat and cold. The Official Disability Guidelines suggest that the hot/cold therapy be in the form packs but not in the form of a motorized unit however. Those guidelines do support the use of heat wraps as treatment for low back pain. Therefore, a motorized cold therapy unit with a hot/cold pad is not medically necessary.