

Case Number:	CM13-0050708		
Date Assigned:	12/27/2013	Date of Injury:	10/13/2005
Decision Date:	05/04/2015	UR Denial Date:	10/30/2013
Priority:	Standard	Application Received:	11/14/2013

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 33-year-old female, with a reported date of injury of 10/13/2005. The diagnoses include right lumbar radiculopathy, status post lumbar fusion, and lumbar levoscoliosis. Treatments to date have included an MRI of the lumbar spine, an x-ray of the lumbar spine, oral medications, lumbar fusion at L4-5 and L5-S1, and electrodiagnostic study of the lower extremities. The progress report dated 08/20/2013 indicates that the injured worker complained of low back pain. The physical examination showed flexion at 30 degrees, extension at 10 degrees, and tenderness to palpation of the lumbar spine. The treating physician requested the purchase or rental of a conductive garment, hot/cold contrast system with deep vein thrombosis/compression unit, Combo Care4 and supplies for the low back.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/Cold Contrast System with DVT/Compression Unit for the Low Back: 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): 287-317. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (Lumbar and Thoracic), Lumbar Support Knee and Leg, Venous Thrombosis and Compression Therapy and Other Medical Treatment Guidelines <http://www.deroyal.com/medicalproducts/orthopedics/product.aspx?id=pc-temptherapy>-cold ther unit.

Decision rationale: MTUS is silent on the use of cold therapy units. ODG for heat/cold packs states 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. 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. The medical documentation provided does not indicate the rationale behind this request. The patient's date of injury was 2005, there is no information included about an upcoming surgery that may warrant this equipment. In addition, the treating physician does not detail why a DVT compression unit is needed. The above guidelines have not been met. Therefore, the request is not medically necessary.

Combo Care4 and Supplies for the Low Back: 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): 287-317, Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120. Decision based on Non-MTUS Citation <http://www.abrexis.com/electrotherapy/combo-care-4>.

Decision rationale: The vendor website states concerning combo care4 Utilizing advanced miniaturization, we have designed an electrotherapy unit that incorporates interferential, TENS, NMS/EMS and syncopation therapies into one unit. ACOEM guidelines state insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists. MTUS further states that interferential units are not recommended as an isolated intervention and details the criteria for selection: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or 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. The treating physicians progress notes do no indicate that the patients has poorly controlled pain, concerns for substance abuse, pain from postoperative conditions that limit ability to participate

in exercise programs/treatments, or is unresponsive to conservative measures. The medical documentation provided does not indicate the rationale behind this request. The patient's date of injury was 2005, there is no information included about an upcoming surgery that may warrant this equipment. Therefore, the request is not medically necessary.

Conductive Garment: 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): 287-317, Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120. Decision based on Non-MTUS Citation <http://www.abrexis.com/electrotherapy/combo-care-4>.

Decision rationale: The vendor website states concerning combo care⁴ Utilizing advanced miniaturization, we have designed an electrotherapy unit that incorporates interferential, TENS, NMS/EMS and syncopation therapies into one unit. ACOEM guidelines state insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists. MTUS further states that interferential units are not recommended as an isolated intervention and details the criteria for selection: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or 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. The treating physician's progress notes do not indicate that the patient has poorly controlled pain, concerns for substance abuse, pain from postoperative conditions that limit ability to participate in exercise programs/treatments, or is unresponsive to conservative measures. The medical documentation provided does not indicate the rationale behind this request. The patient's date of injury was 2005, there is no information included about an upcoming surgery that may warrant this equipment. Therefore, the request is not medically necessary.