

Case Number:	CM14-0179521		
Date Assigned:	11/20/2014	Date of Injury:	05/04/2014
Decision Date:	03/31/2015	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	10/29/2014

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. 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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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, who sustained an industrial injury on 5/4/14. On 10/29/14, the injured worker submitted an application for IMR for review of IF unit & supplies (electrodes x 10 packs, batteries, 10, set-up & delivery), purchase, and Hot cold therapy unit with pad/wrap, purchase. The treating provider has reported the injured worker complained of pain in the low back and left leg with left shoulder and neck down left arm pain. The diagnoses have included elbow sprain/strain. Lumbar radiculopathy, sciatica, knee sprain/strain. Treatment to date has included acupuncture, physical therapy, TENS unit, topical medications, MRI lumbar spine (8/16/14). On 10/22/14 Utilization Review non-certified IF unit & supplies (electrodes x 10 packs, batteries, 10, set-up & delivery), purchase, and Hot cold therapy unit with pad/wrap, purchase. The ACOEM Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF unit & supplies (electrodes x 10 packs, batteries , 10, set-up & delivery), purchase:
 Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chronic Pain Treatment Guidelines Interferential current stimulation (ICS) Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous Electrical Nerve Stimulation Page(s): 97.

Decision rationale: According to MUTUS guidelines, Interferential unit is not recommended as primary treatment modality, but a one month based trial may be considered, if used as an adjunct to a functional restoration program. There is no evidence that a functional restoration program is planned for this patient. Furthermore, there is no documentation of failure of medication or TENS. The patient even reported benefit with TENS. Therefore, the request for an IF unit & supplies (electrodes x 10 packs, batteries, 10, set-up & delivery), purchase is not medically necessary.

Hot cold therapy unit with pad/wrap, purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Disorders (ODG), Elbow (updated 10/20/14) and Low Back Chapter (updated 08/22/2014)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cold/heat packs. (http://www.worklossdatainstitute.verioiponly.com/odgtwc/low_back.htm#SPECT).

Decision rationale: According to ODG guidelines, cold therapy is “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. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) 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. (French-Cochrane, 2006) 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. (Kinkade, 2007) See also Heat therapy; Biofreeze cryotherapy gel”. There is no evidence to support the efficacy of hot and cold therapy in this patient. There is not enough documentation to determine the medical necessity for cold therapy. There is no controlled studies supporting the use of hot/cold therapy in back pain. Therefore, the request for Hot cold therapy unit with pad/wrap, purchase is not medically necessary.