

Case Number:	CM14-0180994		
Date Assigned:	11/04/2014	Date of Injury:	05/12/2014
Decision Date:	03/24/2015	UR Denial Date:	10/06/2014
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: Texas, New York, California
Certification(s)/Specialty: Preventive Medicine, Occupational 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 (IW) is a 23-year-old male who sustained an industrial injury on 05/12/2014. He has reported injury in the left arm, back, and ankle. Diagnoses include lumbar strain with ligament or muscle strain and spasm, multiple trigger points in the lumbar spine, bilateral L5-S1 radiculopathy, left shoulder strain, left shoulder impingement and left ankle sprain. Treatment to date includes use of an ankle boot and ankle brace, wrist brace, ice, rest, medications, physical therapy, and physical restrictions. The IW began chiropractic treatments on 09/13/2014. Diagnostic testing included a MRI of the left shoulder dated 06/11/2014 that showed degenerative changes and mild tendinosis of the supraspinatus tendon, X-rays of the lumbar spine, left ankle, left wrist, and left shoulder on 07/14/2014. A MRI of the lumbar spine done 08/22/2014 showed degenerative disk disease with L4-5 2mm bulge and L5-S1 3mm disc bulge with neural foraminal stenosis and nerve root impingement at the bilateral S1 level and had no findings for acute fracture or additional soft tissue injuries. In a progress note dated 09/04/2014, the treating provider reported tenderness to palpation of the paravertebral muscles bilaterally of the lumbar spine with limited range of motion and restriction of extension and flexion limited by pain. On 09/13/2014, the IW was seen by a chiropractor for ongoing lower back pain that the IW states exacerbates several times a week and can last for several hours. Current pain was rated as a 6/10. On 10/06/2014 Utilization Review non-certified a request for Hot and cold therapy unit, plus pad and wrap for purchase, noting the record review did not reveal evidence of a recent or a planned surgical procedure that would substantiate the necessity for this durable medical equipment. The ACOEM Guidelines, Chapter 9 Shoulder Complaints, as well as the Official

Disability Guidelines (ODG) Shoulder, Cold Packs were cited. On 10/06/2014 Utilization Review non-certified a request for Interferential stimulator, electrodes, batteries, set up and delivery for purchase noting the outcomes of medical management is not specified in the review submitted 10/03/2014 The MTUS Chronic Pain, Interferential Current Stimulation was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential stimulator, electrodes, batteries, set up and delivery for purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 ? 9792.26 MTUS (Effective July 18, 2009) Page 120 of 127.

Decision rationale: No, the proposed interferential stimulator with associated electronics and batteries were not medically necessary, medically appropriate, or indicated here. As noted on page 120 of the MTUS Chronic Pain Medical Treatment Guidelines, purchase of an interferential current stimulator should be predicated on evidence of a favorable outcome during an earlier one-month trial of the same, in terms of increased functional improvement, less reported pain, and medication reduction. In this case, however, the attending provider seemingly sought authorization for purchase of interferential stimulator device without evidence of a previously successful one-month trial of the same. The request, thus, as written, is at odds with MTUS principles and parameters. Therefore, the request was not medically necessary.

Hot and cold therapy unit, plus pad and wrap for purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Cold Packs.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 299. Decision based on Non-MTUS Citation ACOEM V.3 > Low Back > Treatments > Hot and Cold Therapies > Cryotherapies Recommendation: Routine Use of Cryotherapies for Treatment of Low Back Pain Routine use of cryotherapies in health care provider offices or home use of a high-tech device is not recommended for treatment of low back pain. However, single use of low-tech cryotherapy (ice in a plastic bag) for severe exacerbations is reasonable. Strength of Evidence Not Recommended, Insufficient Evidence (I).

Decision rationale: Similarly, the proposed hot and cold therapy unit with associated pad and wrap were likewise not medically necessary, medically appropriate, or indicated here. One of the applicant's primary pain generators is low back. While the MTUS Guideline in ACOEM Chapter 12, Table 12-5, page 299 does recommend at-home local applications of heat and cold as methods of symptom control for low back pain complaints, ACOEM does not, by implication, support higher-tech devices for delivering hot therapy and/or cryotherapy. The Third Edition ACOEM Guidelines take a more explicit position against high-tech devices for delivering cryotherapy explicating noting that such devices are deemed "not recommended." Here, the attending provider did not furnish any compelling applicant-specific rationale or medical evidence which would offset the unfavorable ACOEM position on the article at issue. Therefore, the request was not

medically necessary.