

Case Number:	CM14-0205131		
Date Assigned:	12/17/2014	Date of Injury:	10/22/2012
Decision Date:	02/11/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	12/08/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This is a 46 year old patient with date of injury of 10/22/2012. Medical records indicate the patient is undergoing treatment for lumbar spine sprain/strain, 7-8mm disc protrusion at L5-S1 with spinal stenosis at this level and 3mm disc bulge at L4-L5, facet arthropathy ruled out, possible discogenic pain of lumbar spine. Subjective complaints include low back pain, greater on left, radiates to buttock and left leg, rated 8/10 at worst. Objective findings include straight leg raise negative, tenderness over L4-L5 and L5-S1 facet areas mainly on left, gait is normal, sensation grossly intact. MRI of lumbar spine dated 06/04/2014 revealed 7-8 mm posterior disc protrusion at the narrowed L5-S1 level and a 2mm posterior disc bulge at L4-L5; moderate bilateral L3-L4 facet hypertrophy, neural foraminal narrowing which is moderate on the right at L5-S1 and mild on the left at both L4-L5 and L5-S1. Treatment has consisted of physical therapy, chiropractic treatment, acupuncture, facet block, epidural steroid injection, Naproxen cream, Lodine, Ultracet, Tizanidine and Tylenol #3. The utilization review determination was rendered on 11/05/2014 recommending non-certification of Interferential unit with 16 sets of electrodes, Motorized cold therapy unit and Low back home exercise kit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential unit with 16 sets of electrodes: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s):

Motorized cold. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, TENS chronic pain (transcutaneous electrical nerve stimulation).

Decision rationale: MTUS states regarding TENS unit, "Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below." For pain, MTUS and ODG recommend TENS (with caveats) for neuropathic pain, phantom limb pain and CRPSII, spasticity, and multiple sclerosis. The medical records do not indicate any of the previous conditions. ODG further outlines recommendations for specific body parts: Low back: Not recommended as an isolated intervention Knee: Recommended as an option for osteoarthritis as adjunct treatment to a therapeutic exercise program Neck: Not recommended as a primary treatment modality for use in whiplash-associated disorders, acute mechanical neck disease or chronic neck disorders with radicular findings Ankle and foot: Not recommended Elbow: Not recommended Forearm, Wrist and Hand: Not recommended Shoulder: Recommended for post-stroke rehabilitation ODG further details criteria for the use of TENS for Chronic intractable pain (for the conditions noted above): (1) Documentation of pain of at least three months duration (2) There is evidence that other appropriate pain modalities have been tried (including medication) and failed (3) A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial (4) Other ongoing pain treatment should also be documented during the trial period including medication usage (5) A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted (6) After a successful 1-month trial, continued TENS treatment may be recommended if the physician documents that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. At this point purchase would be preferred over rental. (7) Use for acute pain (less than three months duration) other than post-operative pain is not recommended. (8) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary The medical records do not satisfy the several criteria for selection specifically, lack of documented 1-month trial, lack of documented short-long term treatment goals with TENS unit, and the patient does not get pain relief with oral medications. As such, the request for Interferential unit with 16 sets of electrodes is not medically necessary.

Motorized cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Spine (Acute & Chronic), Continuous-flow cryotherapy.

Decision rationale: MTUS and ACOEM are silent regarding this topic. ODG states, "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated." Progress notes and request for authorization does not detail the length of time for the cold therapy unit, guidelines recommend a 7 day post-operative time period for use of cold therapy units. The treating physician does not include additional information that would justify the use of a cold therapy unit without recent surgical intervention. Additionally, there is little evidence that high tech cold therapy is superior to cold packs that are readily available. As such, the request for Motorized cold therapy unit is not medically necessary.

Low back home exercise kit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar Spine, Home Exercise Kit.

Decision rationale: MTUS does not specifically refer to home exercise kits, but does state "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices." ODG states regarding Home Exercise Kits, "Recommended. See Exercises, where home exercise programs are recommended; & Physical therapy, where active self-directed home physical therapy is recommended." The treating physician does not detail the components that are being requested and utilized in the "low back home exercise kit". There is no clear and specific medical indication for the 'kit' as it is written. As such, the request for Low back home exercise kit is not medically necessary.