

Case Number:	CM14-0066414		
Date Assigned:	07/11/2014	Date of Injury:	08/20/2013
Decision Date:	07/03/2015	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	05/09/2014

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: California, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 40 year old female, who sustained an industrial injury on 08/20/2013. According to a progress report dated 04/09/2014, the injured worker reported severe back pain. She had moderate constant right shoulder pain and mild neck pain. Overall, she felt worse especially in her back. She was not in therapy and was working full time. Medication regimen included Hydrocodone and Flexeril. An MRI did not show a complete tear of the rotator cuff. She had sprain of the acromioclavicular joint with excessive fluid but no arthritic changes. Physical examination of the neck and shoulder demonstrated tenderness, trigger point, spasms to the right greater than the left paracervical region. She had decreased range of motion of her neck by about 20 percent in all directions. Impingement test, adduction test and Neer's test were all positive but mild. The injured worker had mechanical back pain but not radiculopathy. Diagnoses included right shoulder acromioclavicular sprain, right carpal tunnel syndrome, cervical spine sprain/strain, lumbar spine herniated nucleus pulposus at L5-S1 of 4 millimeters, anxiety and insomnia. Treatment plan included physical therapy, Norco, Flexeril, Prilosec and a weight loss program or gastric sleeve. On 04/10/2014, the provider wrote a prescription for X-Force stimulator with garments and a Solar Care heating system. Currently under review is the request for 1 Solar Care infrared heating system and pad purchase, 1 X-Force stimulator unit with purchase of 3 month supplies, 1 TENS unit for joint stimulation with built in TENS feature and 2 conductive garments.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 solar care infrared heating system and pad purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 57 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Low Level Laser Therapy, Low Back Chapter, Cold/Heat Packs.

Decision rationale: Regarding the request for solar care infrared heating system and pad purchase. Chronic Pain Medical Treatment guidelines state that low level laser therapy such as red beam or near infrared therapy is not recommended. Guidelines indicate that there is insufficient evidence to support the use of this modality in the treatment of chronic pain. Regarding heat therapy, Occupational Medicine Practice Guidelines state that various modalities such as heating have insufficient testing to determine their effectiveness, but they may have some value in the short term if used in conjunction with the program of functional restoration. ODG states that heat/cold packs are recommended as an option for acute pain. Within the documentation available for review, there is no indication that the patient has acute pain. Additionally, it is unclear what program of functional restoration the patient is currently participating in which would be used alongside the currently requested heat therapy. Additionally, there is no peer-reviewed scientific literature has been provided which would overrule the guidelines recommendations which do not support infrared treatment. As such, the currently requested solar care infrared heating system and pad purchase is not medically necessary.

1 X force stimulator unit purchase with 3 month supplies: 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 9792.20 - 9792.26 Page(s): 118-120 of 127.

Decision rationale: Regarding the request for X force stimulator unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is

ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested X force stimulator unit is not medically necessary.

1 TENS for joint stimulation with built in TENS feature: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrical nerve stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 114-117 of 127.

Decision rationale: Regarding the request for TENS, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is 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. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial 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. Within the documentation available for review, there is no indication that the patient has undergone a TENS unit trial, and no documentation of any specific objective functional deficits which a tens unit trial would be intended to address. Additionally, it is unclear what other treatment modalities are currently being used within a functional restoration approach. In the absence of clarity regarding those issues, the currently requested TENS unit is not medically necessary.

2 conductive garments: 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 9792.20 - 9792.26 Page(s): 114-117 of 127.

Decision rationale: Regarding the request for conductive garments, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is 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. Guidelines state "form-fitting TENS device: This is only considered medically necessary when there is documentation that there is such a large area that requires stimulation that a conventional system cannot accommodate the treatment, that the patient has medical conditions (such as skin pathology) that prevents the use of the traditional system, or the

TENS unit is to be used under a plaster (as in treatment for disuse atrophy)." Within the documentation available for review, there is no indication that the patient meets criteria for a form-fitting TENS device. As such, the currently requested conductive garments are not medically necessary.