

Case Number:	CM15-0004668		
Date Assigned:	01/13/2015	Date of Injury:	06/13/2014
Decision Date:	03/12/2015	UR Denial Date:	12/18/2014
Priority:	Standard	Application Received:	01/09/2015

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
 Certification(s)/Specialty: Family Practice

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 65 year old female was injured 6/13/14 from a continuous trauma injury from her usual and customary duties. Currently she complains of mid to low back pain radiating to the left lower extremity; neck pain and bilateral wrist and forearm pain. Diagnoses are cervical/ trapezial musculoligamentous sprain/ strain, with anterior spurring from C3 to C6 and positive for early diffuse idiopathic skeletal hyperostosis; thoracolumbar musculoligamentous sprain/ strain with bilateral lower extremity radicular pain and bilateral sacroiliac joint sprain with Grade I anterolisthesis of L4 on L5 facet degeneration at L4-5; bilateral wrist/ forearm sprain/ strain, rule out carpal tunnel syndrome; ankylosing spondylitis. Treatments included chiropractic treatments and home exercise program. Diagnostic studies included radiographs of cervical and lumbar spine, MRI lumbar spine. There was no documentation of ability to perform activities of daily living or functional capacity. The treating physician requested interferential unit, transcutaneous electrical nerve stimulator unit and lumbar spine traction unit. On 12/18/14 Utilization Review non-certified the above listed requests citing MTUS Guidelines Chronic Pain Medical Treatment Guidelines regarding interferential unit, transcutaneous electrical nerve stimulator unit and ODG online: Traction regarding lumbar spine traction.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential unit Qty:1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The MTUS Chronic Pain Guidelines do not recommend interferential current stimulation (ICS) as an isolated intervention as there is no quality evidence. It may be considered as an adjunct if used in conjunction with recommended treatments, including return to work, exercise, and medications if these have not shown to provide significant improvements in function and pain relief, and has already been applied by the physician or physical therapist with evidence of effectiveness in the patient. Criteria for consideration would include if the patient's pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, if the patient has a history of substance abuse, if the patient has significant pain from postoperative conditions which limits the ability to perform exercise programs or physical therapy treatments, or if the patient was unresponsive to conservative measures (repositioning, heat/ice, etc.). A one month trial may be appropriate if one of these criteria are met as long as there is documented evidence of functional improvement and less pain and evidence of medication reduction during the trial period. Continuation of the ICS may only be continued if this documentation of effectiveness is provided. Also, a jacket for ICS should only be considered for those patients who cannot apply the pads alone or with the help of another available person, and this be documented. In the case of this worker, there was insufficient evidence that she had fully exhausted other conservative treatments (medications, formal physical therapy, etc.) to warrant a purchase of an ICS device to use for her back pain. Also, there was no record provided of her having trialed the ICS unit before being recommended it for purchase, which is required before any consideration can be made. Therefore, the interferential unit will be considered medically unnecessary.

TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, TENS Page(s): 114-116.

Decision rationale: The MTUS Guidelines for Chronic Pain state that transcutaneous nerve stimulation (TENS) is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, however, the studies on TENS are inconclusive and evidence is lacking concerning effectiveness. The criteria for the use of TENS, according to the MTUS Guidelines, includes 1. Documentation of pain of at least 3 months duration, 2. Evidence that other appropriate pain modalities have been tried and failed, 3. Documentation of other pain treatments during TENS trial, 4. Documented treatment plan

including the specific short and long-term goals of treatment with TENS, 5. Documentation of reasoning for use of a 4-lead unit, if a 4-lead unit is prescribed over a 2-lead unit. In the case of this worker, the worker was recommended an interferential unit with the second recommendation being for the TENS unit if the interferential unit is not approved. However, in this case, there was insufficient evidence that she had fully exhausted other conservative treatments (medications, formal physical therapy, etc.) to warrant a purchase of an TENS device to use for her back pain. Also, there was no record provided of her having trialed the TENS unit before being recommended it for purchase, which is required before any consideration can be made. Therefore, the TENS unit will be considered medically unnecessary.

Lumbar spine traction unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Traction

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Lower Back section, Traction

Decision rationale: The MTUS ACOEM Guidelines state that lumbar traction does not have high-grade scientific evidence to support its effectiveness or ineffectiveness in the long-term, and is therefore generally not recommended. However, home-based gravity traction may be considered for a trial as an adjunct to a functional restoration program involving exercises to help treat low back pain. Continuation of home-based traction would need to be justified by evidence of functional benefit from previous treatments with traction. In the case of this worker, there was insufficient evidence to suggest the worker was actively engaged (or was planning on being so) in a functional restoration program such as physical therapy to allow an addition of a trial of a home-based traction unit. Therefore, the traction unit will be considered medically unnecessary at this time.