MAXIMUS Federal Services

Case Number:	CM15-0105963		
Date Assigned:	06/10/2015	Date of Injury:	06/04/2013
Decision Date:	07/30/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	06/02/2015

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, Alabama, 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 39 year old male, who sustained an industrial injury on 06/04/2013. He has reported injury to the right shoulder. The diagnoses have included cervical herniated nucleus pulposus of C5-6 with radiculopathy; right shoulder post-traumatic arthrosis of the acromioclavicular joint, severe; radiculopathy of the right shoulder; anxiety; and insomnia. Treatment to date has included medications, diagnostics, injection, and physical therapy. Medications have included Ibuprofen, Tramadol, Naprosyn, Xanax, and topical compounded creams. A progress report from the treating physician, dated 03/19/2015, documented an evaluation with the injured worker. Currently, the injured worker complains of mild to moderate pain in the right shoulder; he is feeling better since he had the injection to the acromioclavicular joint; and he has mild neck pain. Objective findings included neck range of motion is about 20% decreased; and he has 3/4 pain on the right shoulder with extremes of rotation and 0/4 pain on the left. The treatment plan has included the request for Solar Care Heating System, purchase; and X Force Stimulator with supplies, purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

Solar Care Heating System, purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Thermotherapy.

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. Cold and hot therapy could be used as an option for acute pain. However, there are no controlled studies supporting the use of cold and hot therapy in chronic pain. Therefore, the request for Solar Care Heating System is not medically necessary.

X Force Stimulator with supplies, purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post operative pain Page(s): 116-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

Decision rationale: According to MTUS guidelines, "Interferential Current Stimulation (ICS). Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. (Van der Heijden, 1999) (Werner, 1999) (Hurley, 2001) (Hou, 2002) (Jarit, 2003) (Hurley, 2004) (CTAF, 2005) (Burch, 2008) The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues." "While not recommended as an isolated intervention, patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: pain is ineffectively controlled due to diminished effectiveness of medications; or pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or unresponsive to

conservative measures (e.g., repositioning, heat/ice, etc.)." In this case, there is no clear evidence that the patient did not respond to conservative therapies, or has pain that limit his ability to perform physical therapy. There is no clear documentation of failure of pharmacological treatments or TENS therapy. Therefore, the prescription of X Force Stimulator with supplies is not medically necessary.