

Case Number:	CM15-0169461		
Date Assigned:	09/10/2015	Date of Injury:	04/21/2014
Decision Date:	10/08/2015	UR Denial Date:	08/10/2015
Priority:	Standard	Application Received:	08/28/2015

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: California

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 injured worker is a 43 year old female, who sustained an industrial injury on 04-21-2014. The injured worker was diagnosed as having cervical-thoracic-lumbar spine strain. On medical records dated 07-10-2015, the subjective findings noted neck and back pain. Objective findings were noted as having good range of motion and a tender paralumbar was noted. The injured worker was noted to be on modified work duty. Treatments to date included physical therapy. No current medication were listed. The Utilization Review (UR) dated 08-10-2015, was noted to have a Request for Authorization dated 08-04-2015. The UR submitted for this medical review indicated that the request for ice pack with clay and TENS unit were non-certified for not being medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ice pack with clay Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Low Back Complaints Section: Cold Packs.

Decision rationale: The Official Disability Guidelines comment on the use of cold therapy (ice packs) for the treatment of back pain. 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. 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. 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. In this case, the records indicate that the patient is using cold therapy as part of a long-term treatment strategy for chronic pain symptoms. As noted in the above-cited guidelines, cold therapy is only recommended as an option for acute pain. The use of clay as an adjunct to ice pack therapy is not discussed in these guidelines; however, it is clear that the intent of the treatment is the local application of cold therapy. Given that the use of cold therapy is only supported for acute pain, the request for ice packs with clay is not considered as medically necessary.

TENS unit Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of transcutaneous electrotherapy, commonly known as TENS. TENS therapy is typically recommended for the treatment of neuropathic pain. The specific criteria for TENS are as follows: Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. There is evidence that other appropriate pain modalities have been tried (including medication) and failed. 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. Other ongoing pain treatment should also be documented during the trial period including medication usage. A treatment plan including the specific short and long-term goals of treatment with the TENS unit should be submitted. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. In this case, there is insufficient documentation that the patient has neuropathic pain as a component of their chronic pain symptoms. There is no evidence in the history to suggest a neuropathic component. There are no reported findings on physical examination in support of a neuropathic component to this patient's symptoms. The diagnosis used is cervical/thoracic/lumbar/sacral sprain. This diagnosis is not consistent with a neuropathic condition. Finally, there is no evidence in the request for a

one-month trial as recommended in the above cited guidelines. For these reasons, a TENS unit is not medically necessary.