

Case Number:	CM15-0206101		
Date Assigned:	10/22/2015	Date of Injury:	10/08/2010
Decision Date:	12/04/2015	UR Denial Date:	10/12/2015
Priority:	Standard	Application Received:	10/20/2015

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: Emergency 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 48 year old female, who sustained an industrial injury on 10-8-10. The injured worker was being treated for history of lumbosacral spine disc protrusions, status post lumbar spine fusion, bilateral hip strain-sprain and depression. On 5-5-15, the injured worker complains of pain in lower back and bilateral hip; low back pain is rated 5-6 out of 10 (decreased from 6-7 out of 10), right hip pain 7 out of 10 (increased from 6-7 out of 10) and left hip pain 7-8 out of 10 (which was previously 7 out of 10). She is temporarily totally disabled. Physical exam dated 5-5-15 revealed grade 4 tenderness to palpation over the paraspinal muscles unchanged from previous visit and 3-4 palpable spasm; restricted range of motion, positive straight leg raise bilaterally and trigger points are present and grade 2 tenderness to palpation of bilateral hips. Treatment to date has included chiropractic treatment, physical therapy (helps to decrease pain), oral medications including Tramadol and Orphenadrine; lumbar surgery and activity modifications. On 3-30-15 request for authorization was submitted for hot-cold wrap, IF unit, electrodes, batteries and set up and delivery. On 10-13-15 retrospective request for hot-cold wrap, IF unit, electrodes, batteries and set up and delivery was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request Hot/Cold pack wrap DOS 4/20/15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, lumbar and thoracic chapter.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care.

Decision rationale: The requested Retrospective request Hot/Cold pack wrap DOS 4/20/15, is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 8, Neck and Upper Back Complaints, Initial Care, Physical Modalities, Page 174, recommend hot and cold packs only for the first few days of initial complaints. The injured worker has pain in lower back and bilateral hip; low back pain is rated 5-6 out of 10 (decreased from 6-7 out of 10), right hip pain 7 out of 10 (increased from 6-7 out of 10) and left hip pain 7-8 out of 10 (which was previously 7 out of 10). She is temporarily totally disabled. Physical exam dated 5-5-15 revealed grade 4 tenderness to palpation over the paraspinal muscles unchanged from previous visit and 3-4 palpable spasm; restricted range of motion, positive straight leg raise bilaterally and trigger points are present and grade 2 tenderness to palpation of bilateral hips. The treating physician has not documented the medical necessity for this DME beyond the initial first few days of treatment. The criteria noted above not having been met, Retrospective request Hot/Cold pack wrap DOS 4/20/15 is not medically necessary.

Retrospective request for IF Unit, Electrodes, Batteries, set up and delivery DOS 04/20/15: 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): Electrical stimulators (E-stim).

Decision rationale: CA Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy, Interferential current stimulation, Page 118-120, noted that this treatment is "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... There are no published randomized trials comparing TENS to Interferential current stimulation;" and the criteria for its use are: "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.)." The injured worker has pain in lower back and bilateral hip; low back pain is rated 5-6 out of 10 (decreased from 6-7 out of 10), right hip pain 7 out of 10 (increased from 6-7 out of 10) and left hip pain 7-8 out of 10 (which was previously 7 out of 10). She is temporarily totally disabled. Physical exam dated 5-5-15

revealed grade 4 tenderness to palpation over the paraspinal muscles unchanged from previous visit and 3-4 palpable spasm; restricted range of motion, positive straight leg raise bilaterally and trigger points are present and grade 2 tenderness to palpation of bilateral hips. The treating physician has not documented any of the criteria noted above, nor a current functional rehabilitation treatment program, nor derived functional improvement from electrical stimulation including under the supervision of a licensed physical therapist. The criteria noted above not having been met, Retrospective request for IF Unit, Electrodes, Batteries, set up and delivery DOS 04/20/15 is not medically necessary.