

Case Number:	CM14-0122811		
Date Assigned:	09/25/2014	Date of Injury:	07/12/2002
Decision Date:	10/27/2014	UR Denial Date:	07/24/2014
Priority:	Standard	Application Received:	08/04/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 54 year-old female who sustained work-related injuries on July 12, 2002. Per June 17, 2014 initial medical records, the injured worker was at work and tried to lift a desk cabinet however due to activity at hand her back snapped. She presented complaints of lower back pain rated at 7/10 and has soreness and numbness to the left leg. On examination, tenderness was noted over the lumbar spine with paraspinal muscle spasms, left side greater than right. Tenderness over the thoracic spine with paraspinal spasms, left side greater than right, was noted. Range of motion was limited. Sensation was reduced in the left leg. She is diagnosed with (a) status post lumbar surgery x 4 with myospasm and (b) thoracic spine sprain and strain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interspec If li Purchase and Monthly Supplies X3 Months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

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

Decision rationale: Evidence-based guidelines indicate that a prior one-month trial of interferential unit may be appropriate if the injured worker/injured worker meets the Injured

worker Selection Criteria. The criteria notes that pain should be ineffectively controlled due to diminished effectiveness of medications; pain is ineffectively controlled with medications due to side effects; has history of substance abuse; significant pain from postoperative conditions which limits the ability to perform exercise programs/physical therapy; or is unresponsive to conservative measures. In this case, the presented records do not indicate that the injured worker has had a 30-day trial of interferential unit nor has met the any of the above mentioned criteria. Based on these reasons, the medical necessity of the requested Interspec IF II purchase and 3 months supplies is not established.

Hot/Cold Pad Purchase: Upheld

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

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

Decision rationale: Evidence-based guidelines indicate that hot/cold pads or packs are recommended as an option for acute pain. In this case, the injured worker's condition is in the chronic term. There is no indication of an acute exacerbation of pain. Therefore, the medical necessity of the requested hot/cold pad purchase is not established.

Cold Therapy Unit Purchase: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Cold/Heat Packs Official Disability Guidelines (ODG) Shoulder, Continuous-Flow Cryotherapy

Decision rationale: Evidence-based guidelines indicate that at-home local application of cold and heat packs are recommended for acute pain. However, specialized cold therapy units are not supported as there is limited evidence to support its usage. Moreover, evidence-based guidelines indicate that there is minimal evidence supporting the use of cold therapy versus heat therapy. In addition, cold therapy units are only recommended for postoperative use. It is not recommended for non-surgical usage. Due to very little support by evidence-based guidelines and the injured worker is not status post surgery, the medical necessity of the cold therapy unit purchase is not established.

Assy Strap Purchase: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Cold/Heat Packs Official Disability Guidelines (ODG) Shoulder, Continuous-Flow Cryotherapy

Decision rationale: Assy straps are to be used together with a cold therapy unit. Based on the concurrent determination that the requested cold therapy is not medically necessary, the requested Assy strap purchase is also not medically necessary.