

<b>Case Number:</b>	CM14-0181000		
<b>Date Assigned:</b>	11/05/2014	<b>Date of Injury:</b>	11/20/1998
<b>Decision Date:</b>	12/09/2014	<b>UR Denial Date:</b>	10/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2014

### 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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 patient is a 70-year-old man who sustained a work-related injury on November 20, 1998. Subsequently, he developed chronic back and neck and knee pain. According to a progress report dated on August 27, 2014, the patient was complaining of right knee pain associated to left and back pain. The pain severity was rated at 6/10 and his neck and 9/10 and his back. The patient physical examination demonstrated normal neurological examination, antalgic gait with wide base. The patient was using a cane to walk. The patient was treated with the pain medications, surgeries and physical therapy. The patient was reported to have some benefit with Thermacare. The patient MRI lumbar spine demonstrated foramina stenosis at the level of L4 bilaterally with nerve root impingement on the L5 level. The patient was diagnosed with the CTS, Lumbosacral Radiculopathy, Polyneuropathy, Rotator Cuff Sprain and Degenerative Cervical Disease. The Provider Request Authorization for Thermacare heat wraps back L/XL and transcutaneous electrical nerve stimulation (TENS).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Thermacare heat wraps back L/XL:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); ([http://www.worklossdatainstitute.verioiponly.com/odgtwc/low\\_back.htm#SPECT](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 who was suffering from a chronic back and neck pain and who was injured on 1998. Hot and Cold therapy is usually approved during the acute post op setting to treat post op inflammatory swelling. There is no controlled study supporting the use of hot/cold therapy in chronic back and neck pain. Therefore, the request for ThermaCare Heat Wraps is not medically necessary.

**TENS unit with electrodes for purchase:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous Electrical Nerve Stimulation Page(s): 97.

**Decision rationale:** According to MTUS guidelines, TENS is not recommended as primary treatment modality, but a one month based trial may be considered, if used as an adjunct to a functional restoration program. There is no evidence that a functional restoration program is planned for this patient. Per guidelines, the provider should document how TENS will improve the functional status and the patient's pain condition. There is no documentation of one month successful trial of TENS. Therefore, the prescription of TENS unit with electrodes for purchase is not medically necessary.