

Case Number:	CM14-0184517		
Date Assigned:	11/12/2014	Date of Injury:	10/19/2013
Decision Date:	12/18/2014	UR Denial Date:	10/24/2014
Priority:	Standard	Application Received:	11/05/2014

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 31-year-old man with sustained a work-related injury on October 19, 2013. Subsequently, the patient developed low back pain. According to a progress report dated on October 14, 2014, the patient was complaining of low back pain radiating to both lower extremities with numbness and tingling. The pain severity was rated 7/10-5/10. The patient physical examination demonstrated the lumbar tenderness with reduced range of motion, positive straight leg raise on the left side, reduced sensation to light touch over the L5 and S1 dermatome. The provider request authorization for the following treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Solar-Care FIR Heating System: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 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. There is not enough documentation relevant to the patient work injury to determine the medical necessity for cold therapy. Cold and hot therapy could be used as an option for acute pain. However, there is no controlled studies supporting the use of cold and hot therapy in chronic back pain. Therefore, the request for Solar-Care FIR Heating System is not medically necessary.

Kronos Lumbar Pneumatic Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: According to MTUS guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. A lumbar corset is recommended for prevention and not for treatment. Therefore, the request for Kronos Lumbar Pneumatic Brace is not medically necessary.

X-Force stimulator with garments: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation) .

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

Decision rationale: According to MTUS guidelines, Interferential Current Stimulation (ICS) 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. 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 have pain that limit her 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 garments is not medically necessary.