

Case Number:	CM14-0215944		
Date Assigned:	01/06/2015	Date of Injury:	04/01/1997
Decision Date:	03/04/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	12/23/2014

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. 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: Physical Medicine & Rehabilitation

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 74 year old male with an injury date on 4/1/97. The patient complains of lower back pain radiating into the bilateral lower extremities, right > left with numbness/tingling per 10/30/14 report. The patient describes the pain as sharp, constant, throbbing with an intensity of 7-9/10 per 10/30/14 report. The patient also has weakness in his bilateral shoulders, bilateral legs, and bilateral hands per 10/30/14 report. The patient is participating in physical therapy with good results as of 9/8/14 report. Based on the 10/30/14 progress report provided by the treating physician, the diagnoses are: 1. History of lumbar spine surgery in 2004, possibly laminectomy 2. MRI finding of grade 1 retrolisthesis of L1 over L2 and also 3-4 mm disc bulge at L1-2, 5mm disc protrusion at L2-3, 3-4mm disc bulge at L3-4, 2-3mm disc bulge at L4-5, and 2-3 mm disc bulge at L5-S1 with multilevel foraminal foramen narrowing and facet arthrosis. A physical exam on 10/30/14 showed "L-spine range of motion is limited with extension at 0 degrees. straight leg raise positive bilaterally." The patient's treatment history includes medications, MRI lumbar, lumbar surgery, physical therapy, acupuncture, chiropractic treatment. The treating physician is requesting hot/cold wrap purchase, and IF unit with electrodes; battery purchase. The utilization review determination being challenged is dated 12/22/14. The requesting physician provided treatment reports from 6/30/14 to 10/30/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/cold wrap purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation low back chapter, section on hot/cold packs

Decision rationale: This patient presents with lower back pain, pain in lower extremities, weakness in bilateral shoulders/legs/hands. The treater has asked for HOT/COLD WRAP PURCHASE but the requesting progress report is not included in the provided documentation. ODG lumbar chapter recommends hot/cold therapy as an option for acute pain. It recommends at-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. In this case, the patient has chronic back pain. Review of the reports shows there is no exacerbation, new injury, or any change in symptoms. A hot/cold wrap is indicated for acute pain which this patient does not have. The request IS NOT medically necessary.

IF unit with electrodes batteries purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: This patient presents with lower back pain, pain in lower extremities, weakness in bilateral shoulders/legs/hands. The treater has asked for IF UNIT WITH ELECTRODES; BATTERY PURCHASE but the requesting progress report is not included in the provided documentation. Per MTUS guidelines, interferential units are recommended if medications do not work, history of substance abuse or for post-operative pain control. MTUS states: "After a one-month trial there should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person." In this case, the patient is s/p spinal surgery from 2004 and has not had significant improvement. The treater is requesting a interferential unit for post-operative pain control which is reasonable as this patient has failed conservative treatment. However, there is no documentation that the patient has had a prior 1 month trial, and the request appears to be for a purchase of a interferential unit. MTUS guidelines recommend a 1 month trial with documentation of functional improvement. The request IS NOT medically necessary.