

<b>Case Number:</b>	CM15-0016329		
<b>Date Assigned:</b>	02/04/2015	<b>Date of Injury:</b>	03/07/2012
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	01/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2015

### 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, Arizona  
 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 injured worker is a 60-year-old male who reported an injury on 03/07/2012. The mechanism of injury was not specifically stated. The current diagnoses include lumbar spine sprain, right shoulder sprain, and hypertension. The latest physician progress report submitted for review is documented on 10/03/2014. The injured worker reported 7/10 low back pain and 6/10 right shoulder pain. Upon examination, there was positive straight leg raise in the bilateral lower extremities, 50 degree flexion, and tenderness to palpation. Examination of the right shoulder revealed 100 degree abduction, 140 degree flexion, 20 degree extension, and tenderness to palpation. Recommendations at that time included a pain management consultation, prescriptions for compounded creams, an internal medicine consultation, and a Functional Capacity Evaluation. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Water Circulating Heat Pad with Pump:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state at home local applications of heat or cold are as effective as those performed by a therapist. Within the documentation provided, there was no mention of a contraindication to at home local applications of heat or cold as opposed to a motorized mechanical device. Given the above, the request is not medically appropriate.

**Supplies For Existing Electrical Stimulator (TENS) Unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

**Decision rationale:** The California MTUS Guidelines do not recommend transcutaneous electrotherapy as a primary treatment modality, but recommend a 1 month trial as a noninvasive conservative option. In this case, there was no documentation of a failure of other appropriate pain modalities including medication. Additionally, there was no documentation of a successful 1 month trial prior to the request for a unit purchase. Given the above, the request is not medically appropriate in this case.