

<b>Case Number:</b>	CM15-0065112		
<b>Date Assigned:</b>	04/13/2015	<b>Date of Injury:</b>	02/01/2015
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	03/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/06/2015

### 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: New York, Pennsylvania, Washington  
 Certification(s)/Specialty: Internal Medicine, Geriatric Medicine

### 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 28-year-old female, who sustained an industrial injury on 2/1/2015. The current diagnoses are lumbosacral musculoligamentous strain/sprain without radiculitis and rule out lumbosacral spine discogenic disease. According to the progress report dated 2/25/2015, the injured worker complains of mid and low back pain. The pain was not rated. The current medications are Flexeril. Treatment to date has included medication management, modified duties, and physical therapy. The plan of care includes interferential unit, hot/cold unit, 12 physical therapy sessions, and Flexeril.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**IF Interferential Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 308, 167.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 113-1117.

**Decision rationale:** Per the guidelines, a TENS or inferential unit is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters, which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. In this injured worker, other treatment modalities are not documented to have been trialed and not successful. Additionally, it is not being used as an adjunct to a program of evidence based functional restoration. There is no indication of spasticity, phantom limb pain, post-herpetic neuralgia or multiple sclerosis which the TENS unit may be appropriate for. The medical necessity for a TENS unit is not substantiated and is not medically necessary.

**Hot/ Cold Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

**Decision rationale:** At issue in this review is a hot/cold unit. During the acute to subacute phases of injury, physicians can use passive modalities such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise. In this case, there is no documentation of inflammation though the date of injury is likely within the acute to subacute phase of injury. However, it is not clear why ice or hot packs cannot be used instead of a hot/cold unit. The medical necessity for a hot/cold unit is not substantiated by the records and is not medically necessary.

**Physical Therapy 12 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 134.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 98-99.

**Decision rationale:** Physical Medicine Guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active self-directed home physical medicine. In this injured worker, physical therapy has already been used as a modality and a self-directed home program should be in place. The records do not support the medical necessity for additional physical therapy visits in this individual with chronic pain. Therefore, the requested medical treatment is not medically necessary.

