

Case Number:	CM15-0094443		
Date Assigned:	05/21/2015	Date of Injury:	01/31/2014
Decision Date:	06/25/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	05/18/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 47 year old male, who sustained an industrial/work injury on 1/31/14. He reported initial complaints of back pain. The injured worker was diagnosed as having lumbar spine sprain/strain and radiculitis. Treatment to date has included medication, activity modification, transcutaneous electrical nerve stimulation (TENS) unit, and hot/cold therapy. MRI results were reported on 4/24/14 that reported discogenic central stenosis at L4-5, at L4-5 a 7.7 mm broad based central disc protrusion with caudal migration of nuclear material indents the thecal sac and combined with facet hypertrophy narrows the neural foramina and lateral recesses, resulting in impingement of the transiting and encroachment of the exiting nerve roots, mild discogenic spondylosis at L4-5, mild facet arthrosis at L4-S1. Currently, the injured worker complains of constant low back pain and knee pain. Per the primary physician's progress report (PR-2) on 3/31/15, examination revealed tenderness to palpation in the lumbosacral paraspinal muscles and sacroiliac joints. Examination on 4/28/15 and reported radiating pain to the lower extremities with weakness. Neck pain was also reported. Exam revealed tenderness and spasms and decreased range of motion. Ambulation was with a cane due to antalgic gait. The requested treatments include TENS hot and cold unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300, Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation), Criteria for the use of TENS Page(s): 116.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 114-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Cold/Heat Packs.

Decision rationale: Regarding the request for TENS Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) 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. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach, with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. The currently requested TENS is not medically necessary.

Hot and Cold Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Effective July 18, 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cold/Heat Packs.

Decision rationale: Regarding the request for a Cold Therapy Unit, California MTUS and ODG do not specifically address the issue for the low back, although ODG supports cold therapy units for up to 7 days after surgery for some other body parts. For the back, CA MTUS/ACOEM and ODG recommend the use of cold packs for acute complaints. Within the documentation available for review, there is no documentation of a rationale for the use of a formal cold/heat therapy unit rather than the application of simple cold/heat packs at home. Additionally, there is no indication that the patient has undergone a TENS unit trial, and no documentation of any specific objective functional deficits which a tens unit trial would be intended to address. Additionally, it is unclear what other treatment modalities are currently being used within a functional restoration approach. In the absence of clarity regarding those issues, the currently requested Hot and Cold Unit is not medically necessary.