

Case Number:	CM14-0105881		
Date Assigned:	07/30/2014	Date of Injury:	01/05/2010
Decision Date:	08/28/2014	UR Denial Date:	06/02/2014
Priority:	Standard	Application Received:	07/09/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 53-year-old male who reported an injury on 01/05/2010. The mechanism of injury was not specifically stated. Current diagnoses include chronic cervical strain, advanced degenerative disc disease at C5-6, moderate to advanced degenerative disc disease at C5-6, prior C5 vertebral body fracture, degenerative grade I spondylolisthesis of L4-5, moderate disc extrusion of L5-S1 with right lower extremity radiculopathy, right Distal Transcondylar fracture, open reduction and internal fixation of a right patella fracture in 2010, a 5.3 cm right leg length discrepancy, left knee lateral Tibial plateau fracture, right Tibial typical fracture with open reduction internal fixation in 1977, deep vein thrombosis of the right lower extremity, and right ankle sprain. The injured worker was evaluated on 06/23/2014 with complaints of upper and lower back pain as well as bilateral knee and right ankle pain. Physical examination on that date revealed tenderness to palpation with spasm of the upper trapezius muscles, hypoesthesia in the right thumb and fingertips, limited cervical range of motion, tenderness with spasm of the Quadratus Lumborum muscles, limited lumbar range of motion, hypoesthesia in the right knee, decreased grip strength in the right upper extremity, mild inflammation of the right thigh and knee, tenderness to palpation of the right lateral knee and left infrapatellar, limited knee range of motion, mild to moderate inflammation of the right ankle, and exquisite tenderness to palpation of the medial and lateral ankle joints. Treatment recommendations at that time included continuation of the current medication regimen, a podiatry consultation, continuation of aquatic therapy, and a weight loss program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot Cold Therapy Unit: 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): 298-300.

Decision rationale: California MTUS/ACOEM Practice Guidelines state physical modalities have no proven efficacy in treating acute low back symptoms. At-home local applications of heat or cold are as effective as those performed by a therapist. There was no specific body part listed in the current request. There was no total duration of treatment listed in the request. There is no mention of a contraindication to at-home local applications of heat or cold as opposed to a motorized unit. As the medical necessity has not been established, the request is not medically necessary.

ARS Pad/Wrap: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines neurostimulation TENS, Interferential Current Stimulation (ICS) P.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the injured worker's hot/cold therapy unit has not been authorized, the current request is also not medically necessary.

IF Unit Rental 1 (one) month rental: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): Page 117-121.

Decision rationale: California MTUS Guidelines state interferential current stimulation is not recommended as an isolated intervention. There should be documentation that pain is ineffectively controlled due to the diminished effectiveness of medications or side effects, a history of substance abuse, or significant pain from postoperative conditions. The patient does not meet any of the abovementioned criteria as outlined by the California MTUS Guidelines. Furthermore, there is no documentation of a failure to respond to conservative treatment. Based on the clinical information received and the California MTUS Guidelines, the request is not medically necessary.

Electrodes X 2 packs: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): Page 118.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the injured worker's inferential unit has not been authorized, the current request is also not medically necessary.

Batteries X 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the injured worker's inferential unit has not been authorized, the current request is also not medically necessary.