

<b>Case Number:</b>	CM13-0005104		
<b>Date Assigned:</b>	03/21/2014	<b>Date of Injury:</b>	01/18/2012
<b>Decision Date:</b>	04/23/2014	<b>UR Denial Date:</b>	07/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/31/2013

### 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 and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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:

This is a male patient with a date of injury of January 18, 2012. A utilization review determination dated July 25, 2013 recommends non-certification of OrthoStim 4 and a heat pad. Partial certification is recommended for chiropractic sessions. A prescription for therapy dated July 8, 2013 recommends 12 sessions of chiropractic care. A progress report dated July 8, 2013 identifies subjective complaints of neck pain radiating into the left upper extremity, upper back pain, low back pain with numbness and tingling to the left lower extremity, left shoulder pain, and history of sleep difficulties and gastrointestinal upset. Physical examination identifies tenderness to palpation around the cervical spine and musculature with paresthesia in the left C7 nerve root distribution. Lumbar spine examination identifies tenderness to palpation. Diagnoses include cervical/trapezius musculoligamentous sprain/strain, lumbar musculoligamentous sprain/strain, left shoulder Paris scapular myofascial strain, and history of sleep difficulties and gastrointestinal upset. Treatment plan recommends chiropractic therapy 2 times a week for 6 weeks, home interferential unit, and a heating pad.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ORTHOSTIM4 AND SUPPLIES (RENTAL OR PURCHASE):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

**Decision rationale:** Regarding the request for OrthoStim unit, this unit is a combination electrical stimulation unit, which includes TENS, interferential current, galvanic stimulation, and neuromuscular stimulation. In order for a combination device to be supported, there needs to be guideline support for all incorporated modalities. The Chronic Pain Medical Treatment Guidelines state that 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 go on to state the galvanic stimulation is not recommended. Additionally, guidelines state that interferential current stimulation is not recommended as an isolated invention except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Finally, guidelines state that neuromuscular electrical stimulation is not recommended. Within the documentation available for review, there is no indication that the patient is failed a TENS unit trial, as recommended by guidelines prior to an interferential unit trial. Additionally, there is no indication that the interferential current stimulation will be used as an adjunct to program of evidence-based rehabilitation, as recommended by guidelines. Furthermore, guidelines do not support the use of galvanic stimulation or neuromuscular stimulation. As such, the currently requested OrthoStim is not medically necessary.

**HEAT PAD:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Cold/Heat Packs

**Decision rationale:** Regarding the request for a heat pad, the ACOEM Guidelines state that various modalities such as heating have insufficient testing to determine their effectiveness, but they may have some value in the short term if used in conjunction with the program of functional restoration. The ODG states that heat/cold packs are recommended as an option for acute pain. Within the documentation available for review, and there is no indication that the patient has acute pain. Additionally, it is unclear what program of functional restoration the patient is currently participating in which would be used alongside the currently requested heat pad. In the absence of clarity regarding those issues, the currently requested heat pad is not medically necessary.

**CHIROPRACTIC SESSIONS, 2 TIMES A WEEK FOR 6 WEEKS FOR THE CERVICAL SPINE, TRAPEZIUS, LEFT UPPER EXTREMITY, LUMBAR SPINE, AND LEFT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy And Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

**Decision rationale:** Regarding the request for chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, it is unclear exactly what objective functional deficits are intended to be addressed with the currently requested chiropractic care. Additionally, the currently requested 12 treatment sessions exceeds the initial trial recommended by guidelines of 6 visits. In the absence of clarity regarding the above issues, the currently requested chiropractic care is not medically necessary.