

<b>Case Number:</b>	CM13-0007914		
<b>Date Assigned:</b>	09/06/2013	<b>Date of Injury:</b>	06/08/2010
<b>Decision Date:</b>	01/13/2014	<b>UR Denial Date:</b>	07/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/06/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery 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 physician 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.

### 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 patient is a 55-year-old male who reported an injury on 06/08/2010. Currently under consideration is a request for a spinal cord stimulator, a cold therapy unit, and physical therapy. Submitted for review is a partial clinical note dated 07/09/2013 noting only subjective complaints of significant pain regarding the left knee; however, notes indicate that the patient is currently awaiting scheduled surgery and that the left knee is markedly improved with close to 50% to 60% improvement since the surgery approximately 3 months prior. Notes indicate that the patient was measured for Bledsoe knee braces during this visit. Also submitted is an MRI of the cervical spine completed on 05/01/2013. The findings of the MRI included degenerative disc disease and 1.2 mm central broad based disc protrusions at C2-3, C3-4, and C4-5 with the C5-6 level having degenerative disc disease with 1.7 mm right lateral recessed broad based disc protrusion and right neural foraminal stenosis due to uncovertebral arthrosis. At the C6-7 level there was degenerative disc disease and a 1.2 mm central broad based disc protrusion. Also, postural changes were noted with no other abnormalities indicated. Indication for the cervical spine MRI was noted as neck pain with burning pain, numbness and tingling down the bilateral arms.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Spinal cord stimulator:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators Page(s): 105-106.

**Decision rationale:** The California MTUS Guidelines indicate that spinal cord stimulators are recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions to include failed back surgery syndrome and complex regional pain syndrome type 1. Furthermore, criteria for spinal cord stimulation includes a psychological evaluation indicating clearance for the procedure as well as documentation of failure of conservative treatment and permanent placement is indicated only after successful trial with a spinal cord stimulator. The documentation submitted for review was insufficient to detail prior treatment history of the patient for the purposes of determining medical necessity for a spinal cord stimulator. Furthermore, there was a lack of documentation indicating that the patient has undergone a psychological evaluation or a successful trial with a spinal cord stimulator. Given the above, the request for a spinal cord stimulator is not medically necessary and appropriate.

**Cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**Decision rationale:** California MTUS/ACOEM Guidelines do not specifically address cold therapy units. The Official Disability Guidelines indicate that cold therapy units are recommended as an option post surgically; however, they are not recommended for non-surgical treatment. Postoperative use of a cold therapy unit is indicated by the Guidelines as recommended for up to 7 days post surgically including home use. While the documentation submitted for review indicates that the patient is status post surgery for the left knee, the surgery was completed sometime in 04/2013, which indicates that the patient is greater than 7 days postsurgical, thereby negating necessity for postoperative use of a cold therapy unit. Furthermore, there is a lack of clear clinical rationale as to the necessity for a cold therapy unit. Given the above, the request for a cold therapy unit is not medically necessary and appropriate.

**Physical therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

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

**Decision rationale:** The California MTUS Guidelines indicate that physical therapy is recommended with passive therapy to provide short-term relief during the early phases of pain treatment and for controlling symptoms such as pain, inflammation, and swelling as well as to improve the rate of healing of soft tissues. Active therapy is based on the philosophy that therapeutic exercise and/or activity is beneficial for restoring flexibility, strength, endurance,

function, and range of motion. However, there is a lack of documentation indicating prior treatment history of the patient, a current diagnosis for the patient, or recent clinical evaluation which could provide medical necessity for physical therapy. Additionally, the request as stated fails to indicate the requested number of sessions to be attended or for which body part physical therapy is currently being requested. Based on the documentation submitted for review, the patient has significant history of neck pain and knee pain. Given the above, the request for PT is not medically necessary and appropriate.