

<b>Case Number:</b>	CM13-0041723		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	01/06/2013
<b>Decision Date:</b>	03/05/2014	<b>UR Denial Date:</b>	09/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2013

### 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 Physical Medicine & Rehabilitation, and is licensed to practice in Texas. 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. 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 patient is a 29-year-old male who reported an injury on 01/06/2013 due to lifting and bending that caused injury to the low back. Prior treatments included physical therapy, medications, and epidural steroid injections that failed to provide relief for the patient. The patient underwent a lumbar microdiscectomy at the L4-5. The patient's postsurgical treatment plan included a front wheel walker, 3-in-1 commode, home health, postoperative physical therapy, a postoperative TENS unit, and a postoperative cold therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **3 Month Rental of a Transcutaneous Electrical Nerve Stimulator: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG);, Low Back Chapter, Online Version.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulator Page(s): 116.

**Decision rationale:** The clinical documentation submitted for review does provide evidence that the patient underwent surgical intervention. The MTUS Chronic Pain Guidelines do recommend the use of a transcutaneous electrical nerve stimulator in the postsurgical management of a

patient's pain. However, continued use of that mechanism must be based on a 30 day clinical trial. The clinical documentation submitted for review does not provide any evidence that the patient has undergone a 30 day clinical trial to support a 3 month rental. As such, the requested transcutaneous electrical nerve stimulator 3 month rental is not medically necessary and appropriate.

**3 Month Rental of a Hot and Cold Therapy 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 (ODG);Low Back Chapter, Online Version

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG);Knee and Leg Chapter, section on Continuous Flow Cryotherapy

**Decision rationale:** The Official Disability Guidelines recommend the use of a hot/cold therapy unit for up to 7 days as an appropriate duration of treatment in the management of a patient's postsurgical pain. The requested 3 month rental exceeds this recommendation. The clinical documentation submitted for review does not provide any exceptional factors to support extending treatment beyond guideline recommendations. As such, the requested hot and cold therapy unit for 3 month rental is not medically necessary and appropriate.