

<b>Case Number:</b>	CM13-0066361		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	08/18/2012
<b>Decision Date:</b>	06/24/2014	<b>UR Denial Date:</b>	12/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/16/2013

### 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 Interventional Spine, 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:

The patient is a 26 year-old male with an 8/18/2012 date of injury. On 12/2/13, UR reviewed a 10/10/12 report and provided a retrospective denial for: 1) NMES; 2) water circulating heat pain with pump; 3) electrodes per pair; 4) replacement battery for patient owned TENS; 5) lead wires per pair for lumbar spine. The records provided for this IMR did not include the 10/10/12 report or request. The closest report available is the chiropractic report dated 10/2/12 from [REDACTED]. According to the 10/2/12 report, the patient presents with low back pain, and was diagnosed with lumbar sprain and displacement of lumbar disc without myelopathy. On exam, the patient had L5 hypoesthesia, and MRI from 8/31/12 showed L5/S1 disc protrusion displacing the right L5 nerve. The plan was to continue chiropractic care, and acupuncture, and comanagement with an orthopedist, and for shockwave therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE NEUROMUSCULAR STIM ELECTRONC:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: , TENS, CHRONIC PAIN Page(s): 121. Decision based on Non-MTUS Citation MTUS: , TENS, CHRONIC PAIN, 121

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines, for.

**Decision rationale:** The patient is a 26 year-old male who injured his back on 8/18/2012. This IMR pertains to a retrospective request for a neuromuscular electric stimulator (NMES). Limited information is available for this IMR. The UR denial letter refers to a 10/10/12 report, which was not provided for this review. The report closest to that date, is dated 10/2/12 from [REDACTED]. None of the available reports discuss or request the NMES. MTUS guidelines for NMES specifically states it is not recommended, and that there is no support for use for chronic pain. MTUS states it may be for rehabilitation for Stroke, but the reporting does not discuss stroke, and the diagnosis is listed as lumbar sprain. Based on the limited information provided, the request for NMES does not appear to be in accordance with MTUS guidelines. Recommendation is for denial. The request is not medically necessary and appropriate.

**WATER CIRCULATING HEAT PAD WITH PUMP:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold, Number: 0297.

**Decision rationale:** The patient is a 26 year-old male who injured his back on 8/18/2012. This IMR pertains to a retrospective request for a water circulating heat pad with pump. Limited information is available for this IMR. The UR denial letter refers to a 10/10/12 report, which was not provided for this review. The report closest to that date, is dated 10/2/12 from [REDACTED]. None of the available reports discuss or request the water circulating heat pad with pump. MTUS/ACOEM and ODG discuss cold therapy with pumps, but not heat therapy. Aetna guidelines were consulted. Aetna states: "Aetna considers passive hot and cold therapy medically necessary. Mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy." There is no rationale provided on the mechanical circulating heat unit with pump, or rationale why passive hot therapy was not appropriate. The request does not appear to be in accordance with Aetna guidelines. Recommendation is for denial. The request is not medically necessary and appropriate.

**ELECTRODES PER PAIR:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: , TENS, CHRONIC PAIN, Page(s): 121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, for TENS Transcutaneous electrotherapy Page(s): 11.

**Decision rationale:** The patient is a 26 year-old male who injured his back on 8/18/2012. This IMR pertains to a retrospective request for "Electrodes per pair" Limited information is available

for this IMR. The UR denial letter refers to a 10/10/12 report, which was not provided for this review. The report closest to that date, is dated 10/2/12 from [REDACTED]. None of the available reports discuss or request "Electrodes per pair" and there is no indication as to what device the Electrodes are for. It is an incomplete request, without an adequate description. The UR letter mentions 2 electrical devices that may use electrodes, the NMES unit and the patient's TENS unit. MTUS states the NMES unit is not recommended, so electrodes associated with the NMES device would not be necessary. MTUS criteria for TENS states there must be documentation of pain for at least 3-months duration. The request for these items was on 10/10/12 and the date of injury is listed as 8/18/12, so it has not been 3-months, and the patient would not meet the MTUS criteria for TENS therapy, and therefore the electrodes associated TENS would not be necessary. Based on the available information the electrodes for either the TENS unit or the NMES unit would not be necessary as the use of TENS or NMES are not in accordance with MTUS guidelines. Recommendation is for denial. The request is not medically necessary and appropriate.

**REPLACEMENT BATTERY FOR PATIENT OWNED TENS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: , TENS, CHRONIC PAIN Page(s): 121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, for TENS Transcutaneous electrotherapy Page(s): 114.

**Decision rationale:** The patient is a 26 year-old male who injured his back on 8/18/2012. This IMR pertains to a retrospective request for replacment battery for patient owned TENS. Limited information is available for this IMR. The UR denial letter refers to a 10/10/12 report, which was not provided for this review. The report closest to that date, is dated 10/2/12 from [REDACTED]. None of the available reports discuss or request batteries for the patient's TENS unit. The patient does not meet the MTUS criteria for TENS, as MTUS requires documentation of pain for at least 3-months duration, and the injury date is listed as 8/18/12 and the request was apparently on 10/10/12. Since the patient does not meet the MTUS criteria for TENS therapy, the battery associated with the TENS unit is not necessary. Recommendation is for denial. The request is not medically necessary and appropriate.

**LEAD WIRES PER PAIR FOR THE LUMBAR SPINE: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: , TENS, CHRONIC PAIN Page(s): 121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines, for TENS Transcutaneous electrotherapy Page(.

**Decision rationale:** The patient is a 26 year-old male who injured his back on 8/18/2012. This IMR pertains to a retrospective request for "Lead wires per pair for lumbar spine" Limited information is available for this IMR. The UR denial letter refers to a 10/10/12 report, which was not provided for this review. The report closest to that date, is dated 10/2/12 from [REDACTED].

None of the available reports discuss or request "Lead wires per pair for lumbar spine" The UR letter mentions 2 electrical devices that may use the lead wires, the NMES unit and the patient's TENS unit. MTUS states the NMES unit is not recommended, so lead wires associated with the NMES device would not be necessary. MTUS criteria for TENS states there must be documentation of pain for at least 3-months duration. The request for these items was on 10/10/12 and the date of injury is listed as 8/18/12, so it has not been 3-months, and the patient would not meet the MTUS criteria for TENS therapy, and therefore the lead wires associated TENS would not be necessary. Based on the available information the lead wires for either the TENS unit or the NMES unit would not be necessary as the use of TENS or NMES are not in accordance with MTUS guidelines. Recommendation is for denial. The request is not medically necessary and appropriate.