

<b>Case Number:</b>	CM14-0040529		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	01/10/2014
<b>Decision Date:</b>	07/18/2014	<b>UR Denial Date:</b>	02/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2014

### 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 and Rehabilitation 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 45 year-old patient sustained a low back injury on 1/10/14 after picking up a wheelbarrow while employed by [REDACTED]. Request under consideration include Solace Multi Stim Unit 5 month rental with supplies for Lumbar Spine. Diagnoses include lumbago and lumbar radiculitis. Partially legible report of 1/29/14 from the provider noted ongoing low back complaints with radiating down both legs, mainly on right side. There is report of anxiety and stress with 4-5 hours of sleep. Exam showed positive Kemp's test; positive straight leg raise on right (no degree). Tramadol was discontinued due to stomach upset. Under treatment, boxes checked included "MSU", heat/cold pack, home exercise kit for lumbar spine; meds; topical compounded creams; UA; DNA?; MRI; and physical therapy two time six. Modified duty box was checked without specifics. The billings for the Solace MultiStim Unit and all accessories; aqua system with installation fee; along with home exercise kit cost were requested. Report of 1/14/14 noted patient with complaints of low back pain radiating to left buttock rated at 8-10/10 after picking up a wheelbarrow. He denied weakness/numbness/tingling. Exam showed no evidence of muscle spasm, no gross neurological deficit, non-specific tenderness, no acute distress, limited lumbar flex/ext at 60/0 degrees; and no antalgic gait observed on ambulation. X-rays showed degenerative changes with osteophytes without acute fracture or spinal stenosis. Diagnoses were lumbosacral sprain/strain; left lumbar radiculopathy; and lumbago. Treatment include Tramadol, Cyclobenzaprine, Ibuprofen meds; modified work status; PT 3x2; and back support. The request for Solace Multi Stim Unit 5 month rental with supplies for Lumbar Spine was non-certified on 2/21/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Solace Multi Stim Unit 5 month rental with supplies Lumbar Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Page(s): 114, 118, 121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 12th Edition (web0, 2014: Low back - Exercise/Hot and Cold therapy; Knee - Cryotherapy).

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

**Decision rationale:** There is no notation of non-compliance with therapy. X-rays are unremarkable and clinical exam show no specific definitive red-flag findings. Submitted reports have not demonstrated any failed conservative treatment towards a functional restoration program for this patient with what appears to be an uncomplicated lumbar sprain. Per California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of NMES Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication and therapy, none of which has been demonstrated. There is no documented short-term or long-term goals of treatment with any previous TENS unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief from conservative treatment currently being rendered as part of the functional restoration approach to support the request for the NMES Unit trial. There is no evidence for change in work status, increased in activities of daily living (ADLs), decreased visual analog scale score, medication usage, or treatment utilization from the physical therapy treatment already rendered. The Solace Multi Stim Unit 5 month rental with supplies for Lumbar Spine is not medically necessary and appropriate.