

<b>Case Number:</b>	CM14-0071477		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	03/11/1999
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	04/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/16/2014

### 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 Occupational Medicine 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 63 year-old female with date of injury 03/11/1999. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 03/11/2014, lists subjective complaints as pain in the low back. Objective findings: Examination of the lumbar spine revealed tenderness to palpation and spasm along the paraspinal muscles and decreased range of motion in all planes due to pain. There was decreased sensation along L3-4, L4-5, and L5-S1 distribution. Straight leg raise test was positive and sciatic nerve compression was positive. Diagnosis: 1. Cervical disc herniation 2. Bilateral shoulder impingement syndrome 3. Upper extremity overuse tendinopathy 4. Cervical spine strain, status post anterior cervical discectomy and fusion 5. Positive discogram at L5-S1 6. Bilateral thumb tendinitis 7. Right knee pain 8 L3-4, L4-5, and L5-S1 bilateral disc herniation with radiculopathy 9. Left knee internal derangement. Patient has already attended 12 sessions of aqua therapy to date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Aquatic therapy mixed with physical therapy; twelve (12) sessions (2 x 6) lumbar spine:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22 58.

**Decision rationale:** The MTUS states that aquatic therapy can be recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy; but as with therapeutic physical therapy for the low back, it is authorized as a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, prior to authorizing more treatments with a total of up to 18 visits over 6-8 weeks. The patient has been attending aquatic therapy, but the history and physical examination following her last course show no real change in her condition. There is no documentation of objective functional improvement. The request for Aquatic Therapy Mixed With Physical Therapy; Twelve (12) Sessions is not medically necessary.

**New Pro-Stim 5.0 unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Interferential Current Stimulation(ICS). Decision based on Non-MTUS Citation [http://www.vqorthocare.com/Products/SpecSheets/VQO061565REVB OS4 MDBrochure 5.5x8.5.pdf](http://www.vqorthocare.com/Products/SpecSheets/VQO061565REVB_OS4_MDBrochure_5.5x8.5.pdf)The OrthoStim4<http://www.ncbi.nlm.nih.gov/pubmed/1565927> Neuromuscular electrical stimulation; An overview and it's application in the treatment of sport injuries.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain (Chronic), Electrical stimulators.

**Decision rationale:** The ProStim device delivers galvanic stimulation, EMS/NMS, TENS, NMES, and interferential current stimulation (ICS). There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue, shoulder pain, cervical neck pain and knee pain. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. A TENS device is the only recommended treatment. The request for the New Pro-Stim 5.0 unit is not medically necessary.

**Urinalysis:** Upheld

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

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

**Decision rationale:** The MTUS recommends using a urine drug screen to assess for the use or the presence of illegal drugs, a step to take before a therapeutic trial of opioids, to aid in the ongoing management of opioids, or to detect dependence and addiction. There is no

documentation in the medical record that a urine drug screen is needed for any of the above indications. The request for Urinalysis is not medically necessary.