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| Case Number: | CM14-0072711 | | |
| Date Assigned: | 07/16/2014 | Date of Injury: | 06/24/2000 |
| Decision Date: | 08/22/2014 | UR Denial Date: | 04/24/2014 |
| Priority: | Standard | Application Received: | 05/19/2014 |

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:

According to the records made available for review, this is a 51-year-old male with a 6/24/00 date of injury. At the time (4/10/14) of request for authorization for VQ Orthocare Ortho stim 4 and cold therapy unit, there is documentation of subjective (chronic low back pain) and objective (lumbar paraspinal tenderness and pain with lumbar extension) findings, current diagnoses (lumbar degenerative disc disease, lumbosacral spondylosis without myelopathy, and chronic pain syndrome), and treatment to date (medication (Vicodin), physical therapy, chiropractic therapy, and lumbar epidural steroid injection).

IMR ISSUES, DECISIONS AND RATIONALES

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

VQ Orthocare Ortho stim 4 and cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices). Decision based on Non-MTUS Citation Official Disability Guidelines: ACOEM, 2nd Edition, Chapter 12-Low back complaints Official Disability Guidelines: Online Edition, Chapter-Low Back Lumbar & Thoracic (Acute & Chronic) Cold/heat packs see also Heat therapy ; Biofreeze cryotherapy gel. Chapter: Knee & Leg (Acute & Chronic) Continuous-flow cryotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 117-120.

Decision rationale: Regarding VQ Orthocare Ortho stim 4, OrthoStim unit is a combination of neuromuscular stimulation, interferential current stimulation, Galvanic stimulation, and transcutaneous electrotherapy. California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines identify that galvanic stimulation is not recommended and considered investigational for all indications; that neuromuscular stimulation is not recommended and is used primarily as part of a rehabilitation program following stroke with no evidence to support its use in chronic pain. Regarding cold therapy unit, MTUS reference to ACOEM guidelines identifies at-home applications of local heat or cold to the low back as an optional clinical measure for evaluation and management of low back complaints. Official Disability Guidelines (ODG) identifies that there is minimal evidence supporting the use of cold therapy. Within the medical information available for review, there is documentation of diagnoses of lumbar degenerative disc disease, lumbosacral spondylosis without myelopathy, and chronic pain syndrome. However, OrthoStim contains at least one component (Galvanic stimulation) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for VQ Orthocare Ortho stim 4 and cold therapy unit is not medically necessary.