

<b>Case Number:</b>	CM14-0076030		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	02/19/1978
<b>Decision Date:</b>	08/15/2014	<b>UR Denial Date:</b>	04/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/23/2014

### 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, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 67 year old male with a work injury dated 2/19/78. The diagnoses include status post L1-S1 fusion with residual pain, lower thoracic pain, and rule out facet arthropathy. Under consideration is a request for 1 Diagnostic Facet Block In The Thoracic Area At The Level T9-T10, T10-T11, 1 Motorized Cold Therapy Unit For Purchase Only and 1 Combo Stim Electrotherapy. There is a primary treating physician (PR-2) document dated 3/27/14 that states that the patient complains of back pain which is worse pain in the mid and upper back area. The pain interferes with his daily activities and with his sleep. He takes Norco and Baclofen as needed. On physical exam he ambulates with a cane with antalgic gait. He has significant tenderness over the paravertebral muscle area from approximate the area of T8 through T10 bilaterally. He has a midline scar throughout the lumbar region. The treatment plan is to request authorization for diagnostic facet block in the thoracic area at the level of T9-T10, T10-T11. This will be at the level of medial branches. This will be to identify the main pain generator in his back and to see if he is a good candidate for facet denervation at those levels. There is a request for a post injection motorized Cold Therapy Unit for purchase only. There is a request for combo-stim electrotherapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**(1) Diagnostic Facet Block in the thoracic area at the level T9-T10, T10-T11: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back:Facet joint injections, thoracic.

**Decision rationale:** 1 Diagnostic Facet Block In The Thoracic Area At The Level T9-T10, T10-T11 is not medically necessary per the ODG guidelines. The MTUS does not specifically address thoracic facet blocks. The ODG guidelines state that thoracic facet blocks are not recommended. The guidelines state that there is limited research on therapeutic blocks or neurotomies in this region, and the latter procedure (neurotomies) are not recommended. In accordance with the guidelines not recommended facet blocks in this area the request for diagnostic facet blocks cannot be certified and therefore, 1 diagnostic facet block in the thoracic area at the level T9-T10, T10-T11 is not medically necessary.

**(1) Motorized Cold Therapy unit for purchase:** 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) Shoulder, (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee: Continuous-flow cryotherapy.

**Decision rationale:** 1 Motorized Cold Therapy Unit for purchase only is not medically necessary. The guidelines state that The MTUS does not specifically discuss cooling devices but does advocate at home application of ice packs in acute conditions. The ODG guidelines state that continuous flow cryotherapy is recommended as an option after certain surgeries (i.e. Knee), but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. The request for a motorized cold therapy unit for purchase only was requested for post thoracic facet injections which were deemed not medically necessary. It is also not clear why a purchase is necessary over a rental. For these reasons, the request for 1 motorized cold therapy unit for purchase only is not medically necessary.

**1 Combo Stim Electrotherapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines (May 2009); Interferential Current Stimulation (ICS); Criteria for the use of TENS Chronic Pain Medical Treatment Guidelines (May 2009); Neuromuscular electrical stimulation (NMES devices).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices); Interferential Current Stimulation (ICS); transcutaneous electrical nerve stimulation) Page(s): 121; 118-120; 114-116.

**Decision rationale:** 1 combo-stim electrotherapy is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. Per documentation the Combo-STIM facilitates

multi modality electrical stimulation in a single unit; providing Interferential Stimulation and TENS for pain relief along with Neuromuscular Stimulation to lessen the risk of atrophy. The MTUS guidelines state that Neuromuscular electrical stimulation (NMES devices) are not recommended for chronic pain. The NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. The documentation submitted does not reveal patient has had a stroke or is receiving post stroke rehabilitation. The MTUS does not recommend interferential treatment as an isolated intervention. The documentation does not indicate that this interferential unit is being used with an ongoing treatment plan such as exercise or return to work. The MTUS guidelines also do not recommend more than a one month trial and only after patient has met the required criteria. MTUS guidelines recommend TENS as an adjunct to a program of evidence-based functional restoration. Additionally, there should be a treatment plan including the specific short- and long-term goals of treatment with the TENS unit documented. The above documentation does not submit evidence of a treatment plan or an ongoing documented program of evidence based functional restoration. Given the above the request is not medically necessary.