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| Case Number: | CM14-0191244 | | |
| Date Assigned: | 11/25/2014 | Date of Injury: | 11/11/2009 |
| Decision Date: | 01/09/2015 | UR Denial Date: | 11/03/2014 |
| Priority: | Standard | Application Received: | 11/17/2014 |

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:

The patient is a 57 year old male with date of injury 11/11/09. The treating physician report dated 09/18/14 indicates that the patient presents with pain affecting low back and bilateral buttocks. The patient rates their pain as 8-9/10 most of the time. The physical examination findings reveal positive Straight Leg, Gaenslen's, and Patrick's and Fabrer tests, tenderness in the low back, and stiffness of the bilateral hips and knees. Prior treatment history includes physical therapy, acupuncture, aquatic therapy, lumbar ESI, and psychiatric care. MRI findings reveal L3-4 1-2 mm disc protrusion and L5-S1 3-4 mm disc protrusion. The current diagnoses are: 1. Lumbar Disc Herniation. 2. Hypogonadism. 3. Lumbar Musculoligamentous Injury. 4. Lumbar Paraspinal Muscle Spasms. 5. Lumbar Radiculopathy of Lower Extremities. 6. Sacroiliitis of Right Sacroiliac Joint. The utilization review report dated 11/03/14 denied the request for Multi Stim Unit and supplies 30 day rental and Aqua Relief System 30 day rental based on unclear clinical outcomes and guidelines not being met.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multi Stim Unit and supplies 30 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Surgistim/Orthostim Page(s): 120-7.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: The patient presents with pain affecting low back and bilateral buttocks. The current request is for Multi Stim Unit and supplies 30 day rental. It should be noted that the requested treatment device is a Neuromuscular electrical stimulation (NMES). The MTUS guidelines state "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 MTUS guidelines do not recommend the use of these units for chronic pain and there is no documentation that the patient has suffered a stroke. The request is not medically necessary.

Aqua Relief System 30 day rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Continuous-flow cryotherapy units

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and leg: Continuous-flow cryotherapy

Decision rationale: The patient presents with pain affecting low back and bilateral buttocks. The current request is for Aqua Relief System 30 day rental. The Aqua Relief System is a hot/cold therapy pump. The treating physician has not listed any surgeries or use of ice/cold packs. The ODG guidelines for continuous-flow cryotherapy state "Recommended as an option after surgery but not for non-surgical treatment. A cold therapy unit is a type of DME which has little medical efficacy with regards to any advantages over simple ice packs or gel packs. CTU usage is just another form of cold application." In this case there is no documentation of surgery that would require a hot/cold therapy pump and ODG only allows for continuous therapy unit for 7 days post-operatively. The request is not medically necessary.