

<b>Case Number:</b>	CM15-0139952		
<b>Date Assigned:</b>	07/29/2015	<b>Date of Injury:</b>	12/14/2011
<b>Decision Date:</b>	09/02/2015	<b>UR Denial Date:</b>	07/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/20/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 injured worker is a 58 year old male, who sustained an industrial injury on 12-14-11. The diagnoses have included sprain of lumbar, sprain of unspecified site of back, other and unspecified disc disorder, lumbar region and other symptoms referable to back. Treatment to date has included medications, activity modifications, diagnostics, physical therapy, and other modalities. Currently, as per the physician progress supplemental report note dated 5-18/15, the physician notes that the injured worker was in his office for re-evaluation on 4-27-15 regarding requested bilateral laminectomy and decompression L3-4, L4-5 and L5-S1 and it is noted that after the information was relayed it was determined that the above request was approved. There is no other physical exam findings noted. There are no previous diagnostic reports noted regarding the lumbar spine. The physician requested treatments included Pro-Stim 5.0 Plus (unspecified if rental or purchase), 3 months of supplies and Q-Tech Cold therapy unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pro-Stim 5.0 Plus (unspecified if rental or purchase): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Neuromuscular electrical stimulation Page(s): 114-116, 121.

**Decision rationale:** The patient presents with pain affecting the low back. The current request is for Pro-Stim 5.0 Plus (unspecified if rental or purchase). The requesting treating physician report dated 6/4/15 is of poor quality and is only partially legible. The report states, "Pro-Stim 5.0 is requested for purchase for optimal results." This unit is being prescribed as an adjunct to conservative treatment as part of the functional restoration program designed for the patient. The Pro-Stim 5.0 is a dual unit with both TENS and NMES. The MTUS guidelines do support a 30 day trial of a TENS unit for home usage for patients with neuropathy. The treating physician does not document that the patient has had a trial of a TENS unit or a neuro muscular electrical stimulation (NMES) unit. The MTUS does not support NMES usage for the treatment of chronic pain. In this case, the current request is for a dual unit, of which EMS or electrical muscle stimulator, also known as neuromuscular electrical stimulation NMES is specifically not recommended for chronic pain per MTUS. The current request is not medically necessary.

**3 months of supplies:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation Page(s): 121.

**Decision rationale:** The patient presents with pain affecting the low back. The current request is for 3 months of supplies. The requesting treating physician report dated 6/4/15 is of poor quality and is only partially legible. The report states, "Pro-Stim 5.0 is requested for purchase for optimal results." This unit is being prescribed as an adjunct to conservative treatment as part of the functional restoration program designed for the patient. In this case, the request for a Pro-Stim 5.0 unit was not medically necessary; therefore the request for 3 months of supplies is not medical necessary.

**Q-Tech Cold therapy unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG online, Shoulder, Continuous-flow cryotherapy.

**Decision rationale:** The patient presents with pain affecting the low back. The current request is for Q-Tech Cold therapy unit. The treating physician report dated 6/4/15 (26C) states, "Q-Tech Cold Therapy System is recommended for the patient to use after surgery for up to 35-days." The patient will be instructed to use Q-Tech Cold Therapy Recovery System daily for 6-8 hours for up to 35-days after surgery. The MTUS and ACOEM guidelines do not discuss cold/hot therapy

units. The ODG Guidelines has the following regarding continuous-flow cryotherapy: Recommended as an option after surgery but not for non-surgical treatment. Post-operative use generally may be up to 7 days including home use. ODG has the following regarding cold packs, "There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function." The medical reports provided show the patient was authorized for lumbar decompression surgery on 5/18/15. In this case, while a 7 day rental in a post-operative setting may be supported, the current request does not specify a duration in which the Q-Tech Cold Therapy unit is to be used by the patient. Furthermore, the ODG guidelines do not support the purchase of a continuous-flow cryotherapy unit. The current request is not medically necessary.