

<b>Case Number:</b>	CM15-0196956		
<b>Date Assigned:</b>	10/22/2015	<b>Date of Injury:</b>	09/02/2013
<b>Decision Date:</b>	12/09/2015	<b>UR Denial Date:</b>	09/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2015

### 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: Minnesota, Florida  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 48 year old female injured worker suffered an industrial injury on 9-2-2013. The diagnoses included (lumbar) L4-5 and L5-S 1instabilty. On 9-14-2015, the treating provider reported the injured worker had failed chiropractic, physical therapy and medications over a 2-year period for the worsening lumbar pain rated as 9 out of 10. A request for anterior lumbar decompression and fusion was requested and subsequently certified on 9-24-2015. The requested treatments were in consideration of and associated with the approved surgical procedure. Request for Authorization date was 9-14-2015. The Utilization Review on 9-24-2015 determined modification for Muscle stimulator (for re-education) for a TENS unit 30-day rental and non-certified Polar Care hot-cold therapy unit (Unspecified if rental or purchase).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Muscle stimulator (for Re-education): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** The California MTUS chronic pain medical treatment guidelines do not recommend neuromuscular electrical stimulation except as part of a rehabilitation program following a stroke. Galvanic stimulation is also not recommended. It is considered investigational for all indications. H-wave stimulation is not recommended as an isolated intervention. Interferential current stimulation is also not recommended as an isolated intervention. As such, the request for muscle reeducation stimulation is not supported by guidelines and the medical necessity of the request has not been substantiated. The request is not medically necessary.

**Polar Care hot/cold therapy unit (Unspecified if rental or purchase):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation BlueCross BlueShield, Durable Medical Equipment Section- Cooling Devices Used in the Home Setting, DME Policy No. 7.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Low back, Topic: Cold packs.

**Decision rationale:** ODG guidelines recommend cold packs but do not recommend continuous flow cryotherapy for low back surgery. Heat is not recommended. The request as stated does not specify if this is a rental or purchase and if rental, it does not specify the duration of the rental. As such, the medical necessity of the request has not been substantiated. Therefore, the request is not medically necessary.