

Case Number:	CM15-0027573		
Date Assigned:	02/19/2015	Date of Injury:	11/10/1999
Decision Date:	04/07/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	02/12/2015

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

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 November 10, 1999. He has reported LBP. The diagnoses have included chronic pain syndrome. Treatment to date has included medications, physical therapy and lumbar spine arthrodesis. A progress note dated December 17, 2014 indicates a chief complaint of continued lower back pain, leg weakness, and falls. Physical examination showed a slow antalgic gait, tenderness to palpation of the lumbar spine with spasms and tightness, decreased range of motion of the lumbar spine, and decreased strength and sensation of the legs. The treating physician is requesting one VQ orthostim unit with accessories. On January 15, 2015 Utilization Review denied the request citing the California Medical Treatment Utilization Schedule California Chronic Pain Medical treatment Guidelines and American College of Occupational and Environmental Medicine Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 VQ orthostim unit with accessories: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 173, Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS); Neuromuscular Electrical Stimulation (NMES devices); Galvanic Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines neuromuscular electrical stimulation Page(s): 114-121. Decision based on Non-MTUS Citation www.vqorthocare.com.

Decision rationale: The patient presents with low back pain. The request is for VQ ORTHOSTIM UNIT WITH ACCESSORIES. Patient is status post L4-S1 360 arthrodesis 07/25/01, lumbar spine hardware removal 10/15/03, left carpal tunnel release 10/31/05, right shoulder arthroscopy 08/29/08, right knee arthroscopy 01/09/13, umbilical hernia repair 04/12/13 and right thumb surgery 08/25/14. Physical examination on 12/17/14 to the lumbar spine revealed tenderness to palpation to the paralumbar musculature with spasm and tightness and decreased L5-S1 sensation bilaterally, left greater than right and weakness on leg extension against resistance. Range of motion was reduced in all planes with pain and spasm to the thoracic spine. Patient's gait was slow and antalgic with painful heel/toe maneuver. Patient's has had pain management, physical therapy, psychological treatments and medication. Patient's diagnosis per 12/24/14 progress report include chronic pain state, type II Diabetes Mellitus, hypertension, GERD, probable irritable bowel syndrome (IBS), chronic headaches, migraine in type, depression/anxiety, insomnia, hypogonadism due to opiate medication and stress-industrial, asthma, S/P diastasis recti plus umbilical hernia surgery 04/12/13 and S/P right thumb surgery 08/25/14. Per 11/26/14 progress report, patient's medications include Roxicodone 30 mg, Roxicodone 15 mg, Hydrocodone, Lyrica, Voltaren Gel 1%, Maxalt, Byetta, Soma, Lipitor, Metformin, HCTZ, Lisinopril, Januvia, Deplin, Xanax, Viibryd, Valium, Ambien, Fortesta, Ondansetron, Viagra, Invokana, Albuterol Inhaler, and Sertraline. Patient is permanent and stationary. Orthostim per www.vqorthocare.com, is a combination product that includes High Volt pulsed current stimulation, Neuromuscular electrical stimulation and interferential stimulation. Regarding neuromuscular electrical stimulation, MTUS Chronic Pain Medical Guidelines, pages 114-121, state that neuromuscular electrical stimulation devices such as OrthoStim are Not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. For Interferential Current Stimulation (ICS), MTUS guidelines state that Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. These devices are recommended in cases where (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or (4) Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (5) Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). In this case, the treater recommends a VQ OrthoStim unit with accessories to help facilitate rapid recovery for patient's industrial injury. The treater does not specify whether or not the request is for purchase or rental. MTUS does not support NMES units for chronic pain and for IF unit, a rental trial of 30 days are recommended prior to a home unit. The request IS NOT medically necessary.