

Case Number:	CM14-0094369		
Date Assigned:	08/08/2014	Date of Injury:	02/22/2014
Decision Date:	09/15/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	06/20/2014

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 injured worker is a 21-year-old male with a reported date of injury on 02/22/2014. The injury reportedly occurred due to a slip and fall. His diagnoses were noted to include lumbar sprain/strain, lumbosacral radiculitis, muscle spasms, thoracic sprain/strain, and stiffness. His previous treatments were noted to include physical therapy, spinal manipulation, and electrical stimulation. The progress note dated 05/07/2014 revealed the injured worker reported his lower back continued to improve. The injured worker described the symptoms as a dull ache and tightness rated 3/10. The injured worker indicated chiropractic therapy and pain medications were making the symptoms better. The physical examination revealed tenderness to palpation to the paraspinal muscles with spasming and stiffness found in the thoracolumbar region. Facet joint tenderness was noted in the bilateral T8-10, L5. The examination of the low back noted negative Braggard's, faber, and straight leg raise. The deep tendon reflexes were equal and symmetric, and the sensory examination was within normal limits. Request for Authorization form was not submitted within the medical records. The request was for a Solace Multi Stimulator Unit (HCPC E1399) rental 5 months \$ [REDACTED]/monthly. However, the provider's rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Solace Multi Stimulator Unit (HCPC E1399) rental 5 months \$ [REDACTED]/monthly: 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 Transcutaneous electrotherapy stimulation, interferential stimulation Page(s): 116, 118-119.

Decision rationale: The request for a Solace Multi Stimulator Unit (HCPC E1399) rental 5 months \$ [REDACTED]/monthly is not medically necessary. The injured worker complained of pain to his lower back described as dull aching and tightness. The California Chronic Pain Medical Treatment Guidelines do not recommend a TENS unit as a primary treatment modality, but a 1 month home based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence based functional restoration. The guideline criteria for the use of TENS unit is a documentation of pain of at least 3 months duration, evidence that other appropriate pain modalities have been tried and failed, a 1 month trial of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial period. Other ongoing pain treatments should also be documented during the trial period, including medication usage. The interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, or medications, and limited evidence of improvement on those recommended for treatment alone. The randomized trials that have evaluated the effectiveness of the treatment have included studies for back pain, jaw pain, soft tissue and shoulder pain, cervical neck pain, and postoperative knee pain. The guidelines do not recommend the multistim as a primary treatment modality but it is to be used as an adjunct to a program of evidence based functional restoration approach. There is a lack of documentation regarding neuropathic pain to warrant a multistimulator. Additionally, the request for a 5 month rental exceeds guideline recommendations of a 1 month trial. Therefore, the request is not medically necessary.

Electrodes (HCPC A4595) 5 months supply (\$ [REDACTED]): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy stimulation, interferential stimulation Page(s): 116, 118-119.

Decision rationale: The request for a Solace Multi Stimulator Unit (HCPC E1399) rental 5 months \$ [REDACTED]/monthly is not medically necessary. The injured worker complained of pain to his lower back described as dull aching and tightness. The California Chronic Pain Medical Treatment Guidelines do not recommend a TENS unit as a primary treatment modality, but a 1 month home based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence based functional restoration. The guideline criteria for the use of TENS unit is a documentation of pain of at least 3 months duration, evidence that other appropriate pain modalities have been tried and failed, a 1 month trial of the TENS unit should

be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial period. Other ongoing pain treatments should also be documented during the trial period, including medication usage. The interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, or medications, and limited evidence of improvement on those recommended for treatment alone. The randomized trials that have evaluated the effectiveness of the treatment have included studies for back pain, jaw pain, soft tissue and shoulder pain, cervical neck pain, and postoperative knee pain. The guidelines do not recommend the multistim as a primary treatment modality but it is to be used as an adjunct to a program of evidence based functional restoration approach. There is a lack of documentation regarding neuropathic pain to warrant multistimulator supplies and the previous request for a multi-stimulator was non-certified. Additionally, the request for a 5 month rental exceeds guideline recommendations of a 1 month trial. Therefore, the request is not medically necessary.

Lead wires Qty 2 (HCPC A4557) [REDACTED] x 2: 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 Transcutaneous electrotherapy stimulation, interferential stimulation Page(s): 116, 118-119.

Decision rationale: The request for a Solace Multi Stimulator Unit (HCPC E1399) rental 5 months \$ [REDACTED]/monthly is not medically necessary. The injured worker complained of pain to his lower back described as dull aching and tightness. The California Chronic Pain Medical Treatment Guidelines do not recommend a TENS unit as a primary treatment modality, but a 1 month home based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence based functional restoration. The guideline criteria for the use of TENS unit is a documentation of pain of at least 3 months duration, evidence that other appropriate pain modalities have been tried and failed, a 1 month trial of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial period. Other ongoing pain treatments should also be documented during the trial period, including medication usage. The interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, or medications, and limited evidence of improvement on those recommended for treatment alone. The randomized trials that have evaluated the effectiveness of the treatment have included studies for back pain, jaw pain, soft tissue and shoulder pain, cervical neck pain, and postoperative knee pain. The guidelines do not recommend the multistim as a primary treatment modality but it is to be used as an adjunct to a program of evidence based functional restoration approach. There is a lack of documentation regarding neuropathic pain to warrant multistimulator supplies. Additionally, the request for a 5

month rental exceeds guideline recommendations of a 1 month trial. Therefore, the request is not medically necessary.

Adapter (HCPC A9900) \$ [REDACTED]: 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 Transcutaneous electrotherapy stimulation, interferential stimulation Page(s): 116, 118-119.

Decision rationale: The request for a Solace Multi Stimulator Unit (HCPC E1399) rental 5 months \$ [REDACTED]/monthly is not medically necessary. The injured worker complained of pain to his lower back described as dull aching and tightness. The California Chronic Pain Medical Treatment Guidelines do not recommend a TENS unit as a primary treatment modality, but a 1 month home based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence based functional restoration. The guideline criteria for the use of TENS unit is a documentation of pain of at least 3 months duration, evidence that other appropriate pain modalities have been tried and failed, a 1 month trial of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial period. Other ongoing pain treatments should also be documented during the trial period, including medication usage. The interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, or medications, and limited evidence of improvement on those recommended for treatment alone. The randomized trials that have evaluated the effectiveness of the treatment have included studies for back pain, jaw pain, soft tissue and shoulder pain, cervical neck pain, and postoperative knee pain. The guidelines do not recommend the multi-stim as a primary treatment modality but it is to be used as an adjunct to a program of evidence based functional restoration approach. There is a lack of documentation regarding neuropathic pain to warrant multi-stimulator supplies. Additionally, the request for a 5 month rental exceeds guideline recommendations of a 1 month trial. Therefore, the request is not medically necessary.

Aqua Relief System (HCPC E0217) Purchase \$ [REDACTED]: 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), Pain, Heat/Cold packs.

Decision rationale: The request for an Aqua Relief System (HCPC E0217) Purchase \$ [REDACTED] is not medically necessary. The injured worker complains of low back pain. The Official Disability Guidelines recommends heat therapy as an option. A number of studies show

continuous low level heat therapy to be effective for treating low back pain. Active warming reduces low back pain during rescue transfer. Combining continuous low level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared with either intervention alone or control. There is moderate evidence that heat wrap therapy provides a small, short term reduction in pain and disability in acute and subacute low back pain, and that the addition of exercise further reduces pain and improves function. Heat therapy has been found to be helpful for pain reduction and return to normal function. The guidelines state at home, local applications of cold packs in the first few days of acute complaint, thereafter, applications of heat packs or cold packs. Continuous low level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low back is more limited than heat therapy, with only 3 poor quality studies located to support its use, but studies confirm that it may be a low risk, low cost option. 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 guidelines do not recommend cold therapy for chronic low back pain, and therefore, an aqua relief system is not appropriate at this time. Therefore, the request is not medically necessary.

Installation (HCPC A9901) \$ [REDACTED]: 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)), Pain, Heat/Cold packs.

Decision rationale: The request for Installation (HCPC A9901) \$ [REDACTED] is not medically necessary. The injured worker complains of low back pain. The Official Disability Guidelines recommends heat therapy as an option. A number of studies show continuous low level heat therapy to be effective for treating low back pain. Active warming reduces low back pain during rescue transfer. Combining continuous low level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared with either intervention alone or control. There is moderate evidence that heat wrap therapy provides a small, short term reduction in pain and disable in acute and subacute low back pain, and that the addition of exercise further reduces pain and improves function. Heat therapy has been found to be helpful for pain reduction and return to normal function. The guidelines state at home, local applications of cold packs in the first few days of acute complaint, thereafter, applications of heat packs or cold packs. Continuous low level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low back is more limited than heat therapy, with only 3 poor quality studies located to support its use, but studies confirm that it may be a low risk, low cost option. 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 guidelines do not recommend cold therapy for chronic low back pain, and therefore, an aqua relief system is not appropriate at this time. Therefore, the request is not medically necessary.

Lumbar Exercise Rehab Kit (HCPC E1399): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) Knee Chapter DME.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 47.

Decision rationale: The request for a Lumbar Exercise Rehab Kit (HCPC E1399) is not medically necessary. The injured worker complains of low back pain. The California Chronic Pain Medical Treatment Guidelines recommend exercise as there is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated. Such programs should emphasize education, independence, and the importance of ongoing exercise regimen. The guidelines do not recommend one form of exercise over another and the request filed failed to provide the components of the lumbar exercise rehab kit requested. Therefore, the request is not medically necessary.