

<b>Case Number:</b>	CM14-0213487		
<b>Date Assigned:</b>	12/31/2014	<b>Date of Injury:</b>	10/08/2010
<b>Decision Date:</b>	02/25/2015	<b>UR Denial Date:</b>	11/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2014

### 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. 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 & Rehabn, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a female patient with the date of injury of October 8, 2010. A Utilization Review dated November 21, 2014 recommended non-certification of multi stim unit with supplies, 5 months rental; aqua relief system, unspecified if purchase or rental; purchase of cervical kit; and purchase of Aspen summit. A Progress Report dated September 26, 2014 identifies Subjective Complaints of increased pain. Objective Findings identify tenderness over the lumbosacral junction. Muscle strength was decreased at the extensors of the right knee and lower leg with muscle strength being 4/5. Sensation is decreased to pinwheel and lateral aspect of the right lower leg. Diagnoses identify musculoligamentous injury - cervical, lumbar radiculitis, intervertebral disc disorder - cervical, instability cervical, degenerative joint disease back, insomnia, R/O RUE brachial plexopathy, impingement syndrome right shoulder, intervertebral disc disorder - lumbar, radiculopathy - cervical, and cervicogenic headaches. Treatment Plan identifies continues with Solace IFC unit, Aqua Relief System, and back brace.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Multi Stim Unit with supplies, 5 months rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116 and 121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page(s): 114-121.

**Decision rationale:** Regarding the request for Multi stim unit with supplies, 5 months rental, guidelines state in order for a combination device to be supported, there needs to be guideline support for all incorporated modalities. Chronic Pain Medical Treatment Guidelines state that TENS is not recommended as a primary treatment modality, but a one 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. Guidelines go on to state the galvanic stimulation is not recommended. Additionally, guidelines state that interferential current stimulation is not recommended as an isolated invention except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Finally, guidelines state that neuromuscular electrical stimulation is not recommended. Within the documentation available for review, there is no indication that the patient has failed a TENS unit trial, as recommended by guidelines prior to an interferential unit trial. Additionally, there is no indication that the interferential current stimulation will be used as an adjunct to program of evidence-based rehabilitation, as recommended by guidelines. Furthermore, guidelines do not support the use of galvanic stimulation or neuromuscular stimulation. As such, the currently requested Multi stim unit with supplies, 5 months rental is not medically necessary.

**Aqua relief system unspecified if purchase or rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Cold/Heat Packs.

**Decision rationale:** Regarding the request for Aqua relief system unspecified if purchase or rental, California MTUS and ODG do not specifically address the issue for the low back, although ODG supports cold therapy units for up to 7 days after surgery for some other body parts. For the back, CA MTUS/ACOEM and ODG recommend the use of cold packs for acute complaints. Within the documentation available for review, there is no documentation of a rationale for the use of a formal cold therapy unit rather than the application of simple cold packs at home during the initial postoperative period. In the absence of such documentation, the currently requested Aqua relief system unspecified if purchase or rental is not medically necessary.

**Purchase of cervical kit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, Pillow.

**Decision rationale:** Regarding the request for purchase of a cervical kit, this kit is noted to contain cervical pillows. California MTUS does not address the issue. ODG recommends the use of a neck support pillow while sleeping, in conjunction with daily exercise, as either strategy alone did not give the desired clinical benefit. Within the documentation available for review, there is no documentation of adherence to a daily independent home exercise program. In the absence of such documentation, the currently requested purchase of a cervical kit is not medically necessary.

**Purchase of aspen summit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back Chapter, Lumbar Supports

**Decision rationale:** Regarding the request for purchase of Aspen Summit, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states that lumbar supports are not recommended for prevention. They go on to state the lumbar support are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. ODG goes on to state that for nonspecific low back pain, compared to no lumbar support, elastic lumbar belt maybe more effective than no belt at improving pain at 30 and 90 days in people with subacute low back pain lasting 1 to 3 months. However, the evidence was very weak. Within the documentation available for review, it does not appear that this patient is in the acute or subacute phase of his treatment. Additionally, there is no documentation indicating that the patient has a diagnosis of compression fracture, spondylolisthesis, or instability. As such, the currently requested purchase of Aspen Summit is not medically necessary.