

Case Number:	CM15-0116078		
Date Assigned:	06/24/2015	Date of Injury:	05/09/1993
Decision Date:	08/21/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	06/16/2015

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: New York, Tennessee

Certification(s)/Specialty: Emergency Medicine

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 43-year-old male, who sustained an industrial injury on 05/09/1993, secondary to bending, twisting and lifting boxes up to 80 pounds resulting in lower back pain. On most recent provider visit dated 04/16/2015 the injured worker has reported lower back pain. On examination of the lumbar spine revealed tenderness diffusely over the lumbar spine over the paraspinal muscle area. Sciatic notch tenderness was noted on right worse than the left and a decreased range of motion. The diagnoses have included acquired spinal stenosis due to combination of spinal canal, degenerative herniated disc with significant compression of the nerve root at L5-S1 and low back pain with right lower limb radiculopathy. Treatment to date has included laboratory studies, epidural steroid injections, medication and consults. The injured worker underwent a MRI of the lumbar spine without contrast on 04/02/2015 revealed L5-S1 midline disc protrusion and L4-L5 midline disc protrusion and scoliotic curvature. The injured worker was noted as self-employed. The provider requested the following retrospective treatments multiple stim unit, plus supplies, aqua relief system, lumbar kit and aspen summit back brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Multi stim unit, plus supplies DOS: 10/15/2014-03/14/2015 for 3 month rental:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 114-115, 118-119, 121.

Decision rationale: Multi-stim unit is a device that provides TENS, interferential, and neuromuscular stimulation. TENS units are 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, including reductions in medication use, for neuropathic pain, phantom limb pain, spasticity, and multiple sclerosis. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. TENS units are recommended as a treatment option for acute post-operative pain in the first 30 days post-surgery. Transcutaneous electrical nerve stimulation (TENS) appears to be most effective for mild to moderate thoracotomy pain. . It has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. In this case, the patient is not having surgery and is not participating in a functional restoration program. In addition there is no documentation that the patient had used the TENS unit for one month successfully. TENS therapy is not recommended. Interferential current stimulation (ICS) 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 and medications, and limited evidence of improvement on those recommended treatments alone. ICS is indicated when pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, there is a history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment, or the pain is unresponsive to conservative measures. In this case, there is no documentation that any of these conditions exists. ICS is not indicated. Neuromuscular electrical stimulation (NMES) is 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. The request is not medically necessary.

Retro Aqua relief system DOS: 10/15/2014-03/14/2015 for 3 month rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back & Lumbar and Thoracic, Cold/heat packs.

Decision rationale: Aqua relief system is device that provides hot/cold therapy. MTUS does not address this topic. Cold/heat packs are recommended as an option for acute pain. At-home local applications of cold packs are recommended in first few days of acute complaint; thereafter, applications of heat packs or cold packs are recommended. 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 pain is more limited than heat therapy, with only three poor quality studies located that 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. While heat and cold packs are useful for low back pain, there is no recommendation that a Hot and Cold unit is necessary to supply the heat and cold applications to the affected area. Sufficient heat and cold can be applied with the use of hot packs, cold packs, or heating pad. In this case, request for lumbar spinal surgery has been denied. There is no medical necessity for Hot and cold unit. The request should not be authorized.

Retro Lumbar Kit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back- Lumbar & thoracic, Lumbar supports.

Decision rationale: Retro is a lumbar support device/ Lumbar support is not recommended for prevention. It is indicated for compression fractures and specific treatment of spondylolisthesis, and documented instability. It may be used for treatment of nonspecific LBP, but the supporting evidence is very low-quality evidence. In this case, the patient is not suffering from spondylolisthesis or compression fractures. There is no documented instability. There is no indication for lumbosacral support. The request should not be medically necessary.

Retro Aspen Summit Back Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back- Lumbar & thoracic, Lumbar supports.

Decision rationale: Aspen summit back brace is a lumbar support device. Lumbar support is not recommended for prevention. It is indicated for compression fractures and specific treatment of spondylolisthesis, and documented instability. It may be used for treatment of nonspecific LBP, but the supporting evidence is very low-quality evidence. In this case, the patient is not suffering from spondylolisthesis or compression fractures. There is no documented instability. There is no indication for lumbosacral support. The request should not be medically necessary.