

<b>Case Number:</b>	CM14-0148377		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	09/26/1997
<b>Decision Date:</b>	10/20/2014	<b>UR Denial Date:</b>	09/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/12/2014

### 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 Occupational Medicine, 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:

This is a 76-year-old male with a 9/26/97 date of injury. A specific mechanism of injury was not described. According to a progress report dated 7/1/14, the patient reported having intermittent flare-ups of acute low back pain. He has chronic low back pain which radiated into both legs to the bottom of the buttocks, hamstrings, calves to the bottom of both feet more on the right with associated numbness and tingling. He has been using H-wave unit on his back with significant relief in pain. He reported his low back pain as 10/10 without medications and 5-6/10 with medications. Objective findings: tenderness to palpation and muscle spasm in the lumbar paravertebrals, restricted range of motion. Diagnostic impression: lumbar degenerative joint disease, left knee pain, lumbosacral facet syndrome, plantar fasciitis, radiculopathy. Treatment to date: medication management, activity modification, H-wave. A UR decision dated 9/3/14 denied the requests for Multi Stim unit and supplies rental, purchase of aqua relief system, cervical rehab kit, lumbar rehab kit, and cervical traction. Regarding multi stim unit, the RFA does not specify the stimulation type. Regarding aqua relief system, there is no MTUS support for motorized cold units in the treatment of non post op pain. Regarding cervical and lumbar rehab kit, the primary treating physician has not provided evidence that exercises done with the equipment cannot be done with home exercises using no equipment. Regarding cervical traction, there is no documentation of functional benefit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Multi Stim Unit & Supplies Rental (x5 months): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 300, Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

**Decision rationale:** Multi-stim unit incorporates interferential, TENS, NMS/EMS, and galvanic therapies into one unit. However, there is no documentation of a rationale identifying why a combined electrotherapy unit would be required as opposed to a TENS unit. In addition, CA MTUS does not consistently recommend interferential, NMS, and galvanic electrotherapy. Therefore, the request for Multi Stim Unit & Supplies Rental (x5 months) was not medically necessary.

**Aqua Relief System (Purchase):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: [http://www.aetna.com/cpb/medical/data/200\\_299/0297.html](http://www.aetna.com/cpb/medical/data/200_299/0297.html)

**Decision rationale:** CA MTUS and ODG do not address this issue. Aetna considers the use of the Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermolectric Cooling System (an iceless cold compression device), the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source. There is no documentation that the patient has tried and failed the use of standard cold/heat packs. In addition, there is no documentation that this device is for post operative use. Therefore, the request for Aqua Relief System (Purchase) was not medically necessary.

**Cervical Rehab Kit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 173-174.

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

**Decision rationale:** CA MTUS does not address this issue. Before the requested exercise kit can be considered medically appropriate, it is reasonable to require documentation that the patient has been taught appropriate home exercises by a therapist or medical provider and a description of the exact contents of the kit. ODG states that exercise equipment is considered not primarily medical in nature, and that DME can withstand repeated use, is primarily and customarily used

to serve a medical purpose, generally is not useful to a person in the absence of illness or injury and is appropriate for use in a patient's home. There is no documentation that the patient has been participating in a home exercise program that has been instructed by a medical provider, and there is no description of the exact contents of the kit being requested. A specific rationale identifying why a cervical rehab kit would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Cervical Rehab Kit was not medically necessary.

**Lumbar Rehab Kit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

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

**Decision rationale:** CA MTUS does not address this issue. Before the requested exercise kit can be considered medically appropriate, it is reasonable to require documentation that the patient has been taught appropriate home exercises by a therapist or medical provider and a description of the exact contents of the kit. ODG states that exercise equipment is considered not primarily medical in nature, and that DME can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury and is appropriate for use in a patient's home. There is no documentation that the patient has been participating in a home exercise program that has been instructed by a medical provider, and there is no description of the exact contents of the kit being requested. A specific rationale identifying why a lumbar rehab kit would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Lumbar Rehab Kit was not medically necessary.

**Cervical Traction:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cervical Traction

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, Chronic Pain Treatment Guidelines Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter

**Decision rationale:** ODG recommends home cervical patient controlled traction for patients with radicular symptoms, in conjunction with a home exercise program. However, CA MTUS states that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction. In addition, ODG does not recommend powered traction devices. A specific rationale identifying why cervical traction

would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Cervical Traction was not medically necessary.