

Case Number:	CM14-0140546		
Date Assigned:	09/18/2014	Date of Injury:	05/16/2013
Decision Date:	10/23/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/29/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 46-year-old female who reported an injury on 05/16/2013 due to an unknown mechanism. Diagnoses were closed head trauma, post-concussion headaches, lumbar spine sprain and strain, possible lower extremity radiculopathy, lumbarization of S1, disc desiccation at L5-S1, posterior annular tear L5-S1, and a 3 mm disc protrusion L5-S1. Past treatments were medications, massage, and acupuncture. The injured worker had an electromyography (EMG) that revealed chronic bilateral L3 (or L2-4) radiculopathy. Absent bilateral tibial H reflex responses were suggestive of bilateral S1 radiculopathy; however, this is nonspecific. The physical examination on 04/14/2014 revealed range of motion of the lumbar spine for lateral bending was to 22 degrees, flexion was to 52 degrees, and extension was to 28 degrees. Muscle strength was graded at a 5/5 and sensation was within normal limits. Medications were Fexmid and tramadol. The injured worker was undergoing acupuncture treatment twice a week with reported pain relief, decrease in tightness and pain, and improvement in range of motion of the lumbar spine. The Request for Authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transcutaneous electrical nerve stimulation (TENS) Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation) unit.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS; NMES, Interferential Current Stimulation Page(s): 114-116; 121; 118.

Decision rationale: The decision for TENS Unit is not medically necessary. The California Medical Treatment Utilization Schedule recommends a 1 month trial of a TENS unit as an adjunct to a program of evidence based functional restoration for chronic neuropathic pain. Prior to the trial, there must be documentation of at least 3 months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. They do not recommend neuromuscular electrical stimulation (NMES devices) as there is no evidence to support its use in chronic pain. They do not recommend interferential current stimulation (ICS) as an isolated intervention. The injured worker reported she was undergoing acupuncture sessions with increased range of motion and decrease in pain. Other conservative care modalities were not reported as failed. The clinical information submitted for review does not provide evidence to justify a TENS unit. Therefore, this request is not medically necessary.

Solar Care Infrared Heating Pad: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: The decision for Solar Care Infrared Heating Pad is not medically necessary. The Official Disability Guidelines state durable medical equipment is defined as something that can withstand repeated use, i.e., could normally be rented and used by successive patients, 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. The solar care infrared heating pad does not fall under the terms of durable medical equipment. Therefore, this request is not medically necessary.

X-Force Stimulator unit, 30 days rental: 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 Official Disability Guidelines (ODG) Knee, Durable Medical Equipment

Decision rationale: The decision for X-Force Stimulator unit, 30 days rental is not medically necessary. The Official Disability Guidelines state durable medical equipment is defined as something that can withstand repeated use, i.e., could normally be rented and used by successive patients, 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. The X-Force stimulator unit does not fall under the terms of durable medical equipment. Therefore, this request is not medically necessary.