

Case Number:	CM13-0033454		
Date Assigned:	12/06/2013	Date of Injury:	05/13/1996
Decision Date:	07/29/2014	UR Denial Date:	10/03/2013
Priority:	Standard	Application Received:	10/10/2013

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 Orthopedic Surgery, 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 56-year-old female was reportedly injured on 5/13/1996. The mechanism of injury was not listed. The claimant underwent a lumbar interbody fusion at L5-S1 on 1/18/1999. The most recent progress note dated 3/27/2013, indicated that there were ongoing complaints of low back pain. Physical examination demonstrated guarded upright posture, walks with antalgic gait with the aid of a cane. Lumbar spine range of motion was limited by pain. Pain and spasms were 1+. Motor strength and sensation were intact in lower extremities bilaterally. Deep tendon reflexes of Achilles and patellae were 1/4 bilaterally. Plain radiographs, dated 6/7/2012, demonstrated anterolisthesis at L4-L5 with bilateral facet hypertrophy. Previous treatment included moist heat, Transcutaneous Electrical Nerve Stimulation (TENS) unit, lumbar spine support on a daily basis, and medications to include: Seroquel, Cymbalta, Tylenol #3, Anaprox, Flexeril, Protonix and terocin cream. A request was made for retrospective date of service 9/3/2013 #50 electrodes, pair; #12 replacement batteries and #2 lead wires, PAI which were not certified in the utilization review on 10/3/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE DOS 9/3/2013: 50 ELECTRODES, PAIR: 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 : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 116 of 127.

Decision rationale: The California MTUS Guidelines support the use of Transcutaneous Electrical Nerve Stimulation (TENS) as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration for chronic intractable pain. Guideline criteria require a treatment plan including the specific short and long-term goals of treatment. The claimant had chronic back pain after a lumbar spine fusion at L5-S1 in 1999 with anterolisthesis at L4-L5 above the previous fusion. Review of the available medical records failed to document an ongoing evidence-based functional restoration treatment program or any short/long-term goals of treatment. As such, a TENS unit and the requested electrodes are not considered medically necessary. Therefore the request is not medically necessary.

RETROSPECTIVE DOS 9/9/2013: 12 REPLACEMENT BATTERIES: 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 : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 116 of 127.

Decision rationale: The California MTUS guidelines support the use of Transcutaneous Electrical Nerve Stimulation (TENS) as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration for chronic intractable pain. Guideline criteria require a treatment plan including the specific short and long-term goals of treatment. The claimant had chronic back pain after a lumbar spine fusion at L5-S1 in 1999 with anterolisthesis at L4-L5 above the previous fusion. Review of the available medical records did not document an ongoing evidence-based functional restoration treatment program or any short/long-term goals of treatment. As such, a TENS unit and the requested batteries are not considered medically necessary. Therefore the request is not medically necessary.

RETROSPECTIVE DOS 9/9/2013: 2 LEADWIRES, PAI: 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 : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 116 of 127.

Decision rationale: The California MTUS Guidelines support the use of Transcutaneous Electrical Nerve Stimulation (TENS) as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration for chronic intractable pain. Guideline criteria require a treatment plan including the specific short and long-term goals of treatment. The claimant had chronic back pain after a lumbar spine fusion at L5-S1 in 1999 with anterolisthesis at L4-L5 above the previous fusion. Review of the available medical records failed to document ongoing evidence-based functional restoration treatment program or any

short/long-term goals of treatment. As such, a TENS unit and the requested lead wires are not considered medically necessary. Therefore the request is not medically necessary.