

Case Number:	CM13-0044544		
Date Assigned:	06/16/2014	Date of Injury:	07/11/2012
Decision Date:	08/06/2014	UR Denial Date:	10/15/2013
Priority:	Standard	Application Received:	10/31/2013

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 Texas. 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 47 year old male who reported an injury to his low back. No description of the initial injury was provided. The clinical note dated 9/4/13 indicates that the injured worker was utilizing Hydrocodone, Cyclobenzaprine, and a compounded topical cream for pain relief. The note indicates that the injured worker complaining of low back pain that was described as a severe, sharp, stabbing, and burning sensation with numbness and tingling as well as weakness in the lower extremities. Tenderness was identified upon palpation at the paravertebral musculature throughout the lumbar spine. The clinical note dated 2/6/14 indicates the injured worker having previously undergone an L4-5 and L5-S1 decompression on 12/13/13. A well-healed surgical incision was identified. The injured worker continued with complaints of spasms and tenderness as well as guarding throughout the lumbar region. A loss of sensation was identified in the L5 distribution. The operative report dated 12/13/13 indicates the injured worker undergoing an L4-5 and L5-S1 hemilaminectomy. The clinical note dated 9/11/13 indicates the injured worker complaining of decreased sensation in the L4, L5, and S1 distributions.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR 50 ELECTRODES, PER PAIR, PROVIDED 10/1/13:
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.

Decision rationale: The documentation indicates the injured worker having undergone a surgical intervention addressing the low back complaints. The continued use of a transcutaneous device would be indicated provided the injured worker meets specific criteria to include an objective functional improvement with the use of the device. No objective data was submitted confirming the injured worker's positive response to the use of the device. Therefore, it is unclear if the injured worker is experiencing any benefit. Given these factors, the request is not medically necessary.

**RETROSPECTIVE REQUEST FOR 12 REPLACEMENT BATTERIES PROVIDED
10/1/13: 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.

Decision rationale: The documentation indicates the injured worker having undergone a surgical intervention addressing the low back complaints. The continued use of a transcutaneous device would be indicated provided the injured worker meets specific criteria to include an objective functional improvement with the use of the device. No objective data was submitted confirming the injured worker's positive response to the use of the device. Therefore, it is unclear if the injured worker is experiencing any benefit. Given these factors, the request is not medically necessary.

**RETROSPECTIVE REQUEST FOR 2 LEAD WIRES, PER PAIR, PROVIDED 10/1/13:
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.

Decision rationale: The documentation indicates the injured worker having undergone a surgical intervention addressing the low back complaints. The continued use of a transcutaneous device would be indicated provided the injured worker meets specific criteria to include an objective functional improvement with the use of the device. No objective data was submitted confirming the injured worker's positive response to the use of the device. Therefore, it is unclear if the injured worker is experiencing any benefit. Given these factors, the request is not medically necessary.