

Case Number:	CM14-0007198		
Date Assigned:	02/21/2014	Date of Injury:	07/19/2013
Decision Date:	07/11/2014	UR Denial Date:	12/31/2013
Priority:	Standard	Application Received:	01/20/2014

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:

The patient is a 28-year-old female who has submitted a claim for lumbosacral sprain/strain, and sciatica associated with an industrial injury date of 07/19/2013. Medical records from 2013 were reviewed. Patient complained of low back pain, described as sharp and pinching, graded 8/10 in severity. Aggravating factors included prolonged sitting and driving; intake of medication and application of heat pad provided relief of symptoms. Physical examination of the lumbar spine revealed tenderness, and restricted range of motion. Dysesthesia was noted at the left lateral foot. Pain was present upon toe and heel walking. Treatment to date has included physical therapy, and medications such as Cyclobenzaprine, Gabapentin, Nabumetone, and Amitriptyline. Utilization review from 12/31/2013 denied the retroactive (date of service 12-16-2013) request for durable medical equipment: GS/HD combo purchase because the neuromuscular stimulation component of the device is only recommended for post-stroke patients.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROACTIVE (DATE OF SERVICE 12-16-2013) DURABLE MEDICAL EQUIPMENT: GSM/HD COMBO WITH HAN PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit, Neuromuscular Electrical Stimulation Page(s): 114-116, 121.

Decision rationale: A search of online resource revealed that GSM HD Combo is a combination of TENS / muscle stimulator. The MTUS Chronic Pain Medical Treatment Guidelines, state that 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. The MTUS Guidelines states that there are no intervention trials suggesting benefit from neuromuscular electric stimulation for chronic pain; hence, it is not recommended unless following stroke. In this case, patient complained of persistent low back pain despite physical therapy and intake of medications. However, medical records submitted for reviewed failed to provide a rationale for this request. Moreover, progress report from date of service 12/16/2013 was not made available for review. The patient presented with chronic pain; NMES is not recommended for chronic pain as stated above. The medical necessity was not established. Moreover, it is unclear why a rental unit cannot suffice. Therefore, the request for retroactive (date of service 12-16-2013) request for durable medical equipment: GS/HD combo with han purchase is not medically necessary and appropriate.

RETROACTIVE (DATE OF SERVICE 12-16-2013) DURABLE MEDICAL EQUIPMENT: ELECTRODES (8 PRS PER MONTH X3 MONTHS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit, Neuromuscular Electrical Stimulation Page(s): 114-116,121.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

RETROACTIVE (DATE OF SERVICE 12-16-2013) DURABLE MEDICAL EQUIPMENT: BATTERIES (6 AAA PER MONTH X3 MONTHS): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit, Neuromuscular Electrical Stimulation Page(s): 14-116;121.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.