

Case Number:	CM14-0019172		
Date Assigned:	04/23/2014	Date of Injury:	10/27/2009
Decision Date:	07/08/2014	UR Denial Date:	01/20/2014
Priority:	Standard	Application Received:	02/14/2014

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 Family Practice, 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 36-year-old male who reported an injury on 10/27/2009 due to a fall. The clinical note dated 01/08/2014 noted the injured worker presented with frequent low back pain radiating down to the bilateral lower extremities. Previous treatment included Norco, Soma, and a home exercise program. Upon examination of the lumbar spine, range of motion was restricted, there was a positive straight leg raise bilaterally, decreased sensation in the upper extremities in the L5 nerve root and tandem gait was normal. The diagnoses were discogenic low back pain at L5-S1, disc protrusion and annular tear at L5-S1, chronic axial low back pain, depression secondary to pain, insomnia secondary to pain, and status post intradiscal annuloplasty at L5-S1 on 05/24/2013 with more than 50% relief. The current treatment plan included continuation of a home exercise program, continuation of medication treatment, and the provider recommended a purchase of an x-force stimulator and conductive garment with no rationale provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

PURCHASE OF AN X-FORCE STIMULATOR AND CONDUCTIVE GARMENT:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ELECTRICAL STIMULATION.

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

Decision rationale: The request for purchase of an x-force stimulator and conductive garment is not medically necessary. The California MTUS Guidelines do not recommend electrotherapy as a primary treatment modality. A one-month home-based trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidence based functional restoration. There is lack of documentation indicating significant deficits upon physical exam. The efficacy of the injured worker's previous courses of conservative care was not provided. An adequate home-based trial of the x-force stimulator was not documented. The site at which the x-force stimulator and garment was intended for was not provided in the request. Therefore, the request is not medically necessary.