

Case Number:	CM14-0158982		
Date Assigned:	10/02/2014	Date of Injury:	07/06/1989
Decision Date:	10/28/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/29/2014

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 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:

This 56-year-old female sustained an industrial injury on 7/6/89. The mechanism of injury was not documented. Past surgical history was positive for lumbar laminectomy and discectomy surgeries in 1993 and 2001. The 11/12/13 lumbar spine MRI impression documented congenital spinal stenosis, degenerative disc disease at L4/5 and L5/S1, moderate canal stenosis at L3/4 with left foraminal narrowing, severe central canal stenosis at L4/5 with left foraminal narrowing, and moderate central stenosis at L5/S1 with bilateral foraminal narrowing. The 7/24/14 treating physician report cited complaints of sharp, aching, throbbing, and burning moderately severe lumbar pain with associated numbness radiating down the left leg into the toes. Difficulty was documented with prolonged walking, sitting, standing, and activities of daily living. Lumbar exam documented tenderness to palpation, and flexion with pain and spasms. The diagnosis was musculoligamentous sprain, diffuse disc bulges at L4/5 and L5/S1 with degenerative disc disease, chronic left L5 radiculopathy, and insomnia. The treatment plan noted approval for a third lumbar surgery. Medications, including Vicodin and Soma, were refilled as they gave her pain relief and slightly better functional capacity. Authorization was requested for an X-force unit to help decrease pain and spasms and a home exercise kit to help muscle strength. The 9/9/14 utilization review denied the request for a TENS unit as there was no documentation of associated physical therapy or any active skilled intervention to be paired with the TENS use. The request for a home exercise kit was denied as there was limited evidence of the need of specialized equipment to perform a home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-Force Unit for Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: Under consideration is a request for an X-Force unit for the lumbar spine. Vendor documentation indicates that this is a TENS unit. The California MTUS guidelines state that a one-month home-based TENS unit trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for certain conditions. Supported indications included neuropathic pain. Criteria for the use of TENS include chronic intractable pain with evidence that other appropriate pain modalities have been tried (including medications) and failed. Guideline criteria have not been met. There is no current evidence that a program of functional restoration is in place. There is no documentation that medications have failed and other appropriate pain modalities have been tried and failed. This request for unknown length of use is not consistent with guidelines. Therefore, this request is not medically necessary.

Home exercise kit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation Low Back Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47.

Decision rationale: The California MTUS supports the use of exercise for patients with chronic pain. Exercise programs are reported superior to treatment programs that do not include exercise. Guidelines state that there is no sufficient evidence to support the recommendation of any particular exercise regime over any other exercise regime. Guideline criteria have not been met. There is no compelling reason to support the medical necessity of a pre-packaged generic lumbar exercise kit over an individualized home exercise program designed by the patient's physical therapist. Therefore, this request is not medically necessary.