

Case Number:	CM14-0021442		
Date Assigned:	05/07/2014	Date of Injury:	05/24/2003
Decision Date:	07/09/2014	UR Denial Date:	02/19/2014
Priority:	Standard	Application Received:	02/20/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Nevada. 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 58 year-old male who sustained an injury on 5/24/2003. The claimant was injured while working on a farm picking grapes when he stepped into a hole and fell backwards on the ground landing on the left side and low back. The claimant underwent a laminectomy and discectomy at L5/S1 on 6/10/2003; followed by a decompression and fusion at L5/S1 on 11/2/2010. At the most recent office visit dated 1/29/2014, the claimant complained of constant low back pain that radiated to the left lower extremity with numbness in the left foot. Physical examination demonstrates the claimant ambulates with a cane with discomfort. Lumbar spine exam reveals tenderness to palpation of the lumbosacral region; range of motion is restricted and painful with guarding; hyperextension of the low back causes radiation of pain into the buttocks and posterior thighs; a healed surgical scar is noted on the low back; paraspinal muscles symmetrical without swelling or muscle spasm. Straight leg raise test is positive in the left lower extremity. Positive Lasegue's sign. Gaenslen test is negative. Pelvic compression test is negative. Bent-knee femoral stress test is negative bilaterally. Deep tendon reflexes are 2+ and symmetrical at both knees and ankles. Muscle strength is 5/5 in the lower extremities bilaterally. Sensation is intact on the right; decreased in the L4, L5, and S1 nerve distributions on the left. Imaging studies include an x-ray of the lumbar spine shows evidence of decompression and fusion at L5/S1, pedicle instrumentations are in position. Recent diagnostic studies included an MRI of the lumbar spine dated 4/5/2013 which showed a previous spinal fusion surgery at L5/S1 with posterior riding screw apparatus at L5/S1; postsurgical bony and soft tissue changes at L5/S1; levoscoliosis, hemangioma, multilevel discogenic disease; L3/4 a 3 mm anterior disc protrusion; L4/5: facet arthropathy bilaterally. EMG/NCV study dated 4/10/2013 was abnormal and showed findings suggestive of a diffuse sensory polyneuropathy secondary to underlying diabetic condition; abnormal electromyography; findings are suggestive of B/L chronic active

L5/S1 radiculopathy. Medications listed for treatment include Tramadol 150 mg and Prilosec 20 mg to protect their stomach. The request has been made for an X Force Stimulator Unit +3 month supply, two conductive garments and one solar care heating system. The previous determination dated 2/18/2014 appears to be based on failure to reveal any guidelines or scientific evidence to support the safety and efficiency of the requested devices in the management of chronic back pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 X - FORCE STIMULATOR UNIT PLUS THREE MONTH SUPPLIES: Upheld

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

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

Decision rationale: CA MTUS, ACOEM and ODG guidelines do not comment on the X Force Stimulator Unit; however, the CA MTUS Chronic Pain Medical Treatment Guidelines do not recommend transcutaneous electrical nerve stimulation as a primary treatment modality. Given the safety, efficacy and long-term outcomes/risks are unavailable; the X Force Stimulator Unit is considered an experimental treatment and cannot be considered medically necessary.

2 CONDUCTIVE GARMENTS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Joint Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Transcutaneous electrotherapy Page(s): 114-116.

Decision rationale: As outline by the American College of Occupational and Environmental Medicine Guidelines, the X Force Stimulator Unit is not considered medically necessary or appropriate, therefore, the requested conduction garments are not considered medically necessary.

1 SOLAR CARE HEATING SYSTEM: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) ACOEM

Practice Guidelines, Low Back Disorders, Clinical Measures - Hot Packs, Heat Wraps, and Moist Heat.

Decision rationale: The ACOEM practice guidelines do not recommend heat treatment for chronic low back pain. When considering the claimant's date of injury, clinical presentation and the lack of any competent, objective and independently confirmable medical evidence to suggest any efficacy, utility or benefit from such intervention, there is no clear clinical data presented to support this solar care heating system. Therefore, the request for 1 solar care heating system is not medically necessary and appropriate.