

<b>Case Number:</b>	CM14-0024715		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	06/15/2009
<b>Decision Date:</b>	07/24/2014	<b>UR Denial Date:</b>	02/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/26/2014

### 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 and Rehabilitation 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 patient is a 45 year old male who was injured on 06/15/2009. The mechanism of injury is unknown. The patient underwent a laminectomy with decompression of L4-L5 and L5-S1 in 05/20/12. The patient's medications included Prozac 20 mg, Tramadol 150 mg, and Prilosec 20 mg. Diagnostic studies reviewed include MRI of the lumbar spine dated 12/06/2013 revealed disc abnormalities at L3-L4, L4-L5, and L5-S1. The patient also received an EMG/NCV of the lower extremities on 12/18/2013 which revealed a normal nerve conduction study and an abnormal electromyography which is suggestive of bilateral chronic active L4-L5 radiculopathy, left side greater than the right side. Comprehensive Orthopedic re-evaluation note dated 11/26/2013 reports the patient complained of severe low back pain which is constant and radiates into his legs, more on the left than the right. He was taking Tramadol 150 mg for pain, Prilosec 20 mg to protect the stomach and Prozac 20 mg once a day. On exam, the patient moved very slowly and has a slight limp because of the pain in his left leg. Sitting straight leg raise on the right is +70 and on the left ++70 with normal being -90; Lying straight leg raise test revealed +++30 bilaterally with normal being -70. His reflexes are intact. His sensation is slightly decreased bilaterally at L4 through S1. Diagnoses are 1) depression/anxiety 2) insomnia 3) sexual dysfunction 4) rule out spinal infection and 5) Chronic sacroiliac joint pain Prior utilization review dated 02/24/2014 states the request for one X-force stimulator unit with three months of supplies, 2 X-force stimulator garments, one solar care heating system, and one spinal cord stimulator were not certified. There is no evidence to fulfill guideline criteria for the use of a spinal cord stimulator. There is a lack of documented evidence of any failed treatments and the remaining requests are denied.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ONE X-FORCE STIMULATOR UNIT WITH THREE MONTHS OF SUPPLIES.:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Low back, Electrical stimulators (E-stim), TENS (transcutaneous electrical nerve stimulation); Other Medical Treatment Guideline or Medical Evidence: SevenSeas distribution and manufacturing LLC <http://www.sevenseasdm.com/force-stimulator/>.

**Decision rationale:** According to the literature provided by the product manufacturer, the X-Force Stimulator is a small hand-held portable unit device, it is a dual modality unit, offering TEJS and TENS functions for therapeutic electrical stimulation for the purpose of pain relief. The X-Force consists of electrodes, the lead wires, and the signal generator. According to the Official Disability Guidelines for chronic conditions, TENS is not generally recommended as there is strong evidence that TENS is not more effective than placebo or sham. The guidelines state TENS is not recommended as an isolated intervention, but a one-month home-based TENS trial may be considered as a noninvasive conservative option for chronic back pain, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration, including reductions in medication use. The request for purchase of the device is not supported by the medical records and is not recommended under the guidelines. In addition there is no mention of participation in a program of functional restoration. Furthermore, the medical records do not provide evidence the patient has failed standard conservative care measures. The medical records do not establish the requested electrical stimulator device and supplies is medically necessary.

**2 X-FORCE STIMULATOR GARMENTS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

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

**ONE SOLAR CARE HEATING SYSTEM:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Low Back, Infrared therapy (IR), Heat therapy.

**Decision rationale:** According to the Official Disability Guidelines, infrared heat is not recommended over other heat therapies. In addition this heat device does not meet the criteria of a DME, it is not medical in nature. The submitted medical records do not provide a rationale for the requested heating system. Simple at home applications of heat can suffice for delivery of heat therapy. The medical literature does not substantiate an IR solar heat source device is medically necessary for the management of the patient's injury. The medical necessity of this request is not established.

**ONE SPINAL CORD STIMULATOR:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Spinal Cord Stimulator Section.

**Decision rationale:** The Official Disability Guidelines state spinal cord stimulation is recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated, and only after a successful trial. The medical records do not establish this patient meets all the necessary criteria and indicators for spinal stimulator implantation.