

Case Number:	CM14-0082709		
Date Assigned:	07/21/2014	Date of Injury:	09/27/2006
Decision Date:	09/16/2014	UR Denial Date:	06/02/2014
Priority:	Standard	Application Received:	06/04/2014

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 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 62 year-old patient sustained an injury on 9/27/06 while employed by [REDACTED]. The request under consideration includes a thirty day rental for a transcutaneous electrical nerve stimulation (TENS) unit for management of symptoms related to a lumbar spine injury and purchase of a lumbar brace for the management of symptoms related to a lumbar spine injury. Diagnoses include thoracic/lumbosacral neuritis/radiculitis. A report of 5/1/14 from the provider noted the patient with ongoing chronic neck and low back pain rated at 7/10, radiating to bilateral legs associated with numbness. Medications included Gabapentin, Methoderm gel, Naproxen, Orphenadrine ER, and Pantoprazole. Exam showed decreased sensation at right thumb, index, and middle finger; lumbar spine with tenderness and paravertebral muscle spasm, tight muscle bands bilaterally; No radicular symptoms with Spurling maneuver; tenderness at cervical spine and trapezius. Diagnoses included lumbago, cervicgia, thoracic sprain/strain, thoracic and lumbosacral neuritis/ radiculitis, and therapeutic drug monitoring. The request for a thirty day rental for a TENS unit for management of symptoms related to a lumbar spine injury and purchase of a lumbar brace for the management of symptoms related to a lumbar spine injury was non-certified on 6/2/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Thirty day rental for a TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116 and 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-117.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress, and functional restoration has not been demonstrated. Specified criteria for the use of a TENS Unit include a trial in adjunction to ongoing treatment modalities, within the functional restoration approach, as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication, therapy, and modified activities. It appears the patient has received extensive conservative treatment to include medications, therapy modalities, and rest; however, functional status and pain relief remain unchanged for this chronic 2006 injury. There is no documented short-term or long-term goals of treatment with the TENS unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the TENS Unit trial. As such, the request is not medically necessary.

Purchase of a lumbar brace: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: There are no presented diagnoses of instability, compression fracture, or spondylolisthesis with spinal precautions to warrant a back brace for chronic low back pain. Reports have not adequately demonstrated the medical indication for the LSO. Based on the information provided and the peer-reviewed, nationally recognized guidelines, the request for an LSO cannot be medically recommended. MTUS Guidelines note lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. This patient is well beyond the acute phase of injury of 2006. Submitted reports have not adequately demonstrated indication or support for the request beyond the guideline recommendations and criteria. As such, the request is not medically necessary.