

Case Number:	CM14-0090771		
Date Assigned:	07/23/2014	Date of Injury:	12/27/2007
Decision Date:	08/28/2014	UR Denial Date:	05/21/2014
Priority:	Standard	Application Received:	06/16/2014

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 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 53-year-old male who was reportedly injured on 12/27/2007. The mechanism of injury was not listed. A progress note, dated 5/8/2014, made a request for 1 X-Force stimulator and 1 Kronos lumbar pneumatic brace, which were not certified in the utilization review on 5/01/2014. There were multiple ongoing complaints to include chronic back pain as well as intermittent neck, mid back, bilateral shoulders, arms, hand/wrist, legs and right foot pains. Physical examination was illegible. No diagnostic imaging studies available for review. Previous treatment included physical therapy, chiropractic care, psychological treatment and medications. The injured worker has been temporarily totally disabled since 12/27/2007.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 X-Force stimulator: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Chronic Pain (transcutaneous electrical nerve stimulation), Criteria for the use of TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 114-116.

Decision rationale: The California Medical Treatment Utilization Schedule 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.

1 Kronos lumbar pneumatic brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 301. Decision based on Non-MTUS Citation Official Disability Guidelines- Low Back- Lumbar and Thoracic (Acute and Chronic).

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

Decision rationale: American College of Occupational and Environmental Medicine treatment guidelines do not support the use of a lumbar sacral orthotic or other lumbar support devices for the treatment or prevention of low back pain except in cases of specific treatment of spondylolisthesis, documented instability, or postoperative treatment. The injured worker is currently not in an acute postoperative setting and there is no documentation of instability or spondylolisthesis with flexion or extension and plain radiographs of the lumbar spine. As such, this request is not considered medically necessary.