MAXIMUS Federal Services

Case Number:	CM15-0003235		
Date Assigned:	01/14/2015	Date of Injury:	11/07/2005
Decision Date:	03/20/2015	UR Denial Date:	12/15/2014
Priority:	Standard	Application Received:	01/07/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Minnesota, Florida
Certification(s)/Specialty: Orthopedic Surgery

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 54 year old female who sustained an industrial motor vehicle accident injury reported on 11/7/2005. She has reported having low back pain with bilateral leg and left upper extremity weakness; resulting in difficulty ambulating. The diagnoses have included status-post right total hip arthroplasty (with recurrent dislocation) and cervical laminotomy with fusion; persistent left upper extremity paresthesia and weakness; degenerative spondylolisthesis with severe central lumbar canal stenosis; pressure on the cauda equine; and obesity. Treatments to date have included consultations; multiple diagnostic imaging studies; multiple surgeries (cervical spine - 5/10/11 and hip 10/7/08) with post-operative rehabilitation; a walker and wheelchair; transcutaneous electrical stimulation unit - now broken; home health/nursing/physical therapy; and medication management. The injured worker was noted to be classified as temporarily totally disabled and unable to return to work. On 12/15/2014 Utilization Review non-certified, for medical necessity, the request for the purchase of transcutaneous electrical stimulation unit and moist heating pad, noting the Medical Treatment Utilization Schedule for chronic pain medical treatment Guidelines and transcutaneous electrical stimulation unit guidelines and Official Disability Guidelines for the knee and leg, were cited.The 11/18/2014 PR-2 shows a request for a new transcutaneous electrical stimulation unit based on the degree of progress with her current treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: New TENS Unit (Purchase) QTY: 1.00: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation Page(s): 114, 115.

Decision rationale: Transcutaneous electrical nerve stimulation is recommended after a one-month home based trial as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. However, it is not recommended as a primary treatment modality. The documentation indicates that the injured worker had already been certified for a transcutaneous electrical nerve stimulation unit and this request was for a replacement unit. Therefore the request is appropriate and the medical necessity is established.

DME: Moist Heating Pad (Maximum cost [redacted]) QTY: 1.00: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 7th Edition, Current Year (2009) On-Line Knee and Leg Chapter (Updated 11/29/12), DME

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Section; Knee, Topic Durable Medical Equipment

Decision rationale: ODG guidelines recommend durable medical equipment if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. Cold/heat packs are classified as durable medical equipment and meet the Medicare definition. It can withstand repeated use and is primarily and customarily used to serve a medical purpose. It is generally not useful to a person in the absence of illness or injury and is appropriate for use in a patient's home. The request for the heating pad is appropriate and is medically necessary.The request as stated includes a maximum cost of [redacted] which is appropriate.