

Case Number:	CM15-0108530		
Date Assigned:	06/15/2015	Date of Injury:	08/26/2008
Decision Date:	07/15/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/05/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 60 year old male patient who sustained an industrial injury on 08/26/2008. A primary treating office visit dated 04/14/2015 reported the patient with subjective complaint of having back pain described as dull aching pain that is constant and radiates to arms and legs. He is with limited back motion, rigidity, guarding and spasm. Objective assessment found the patient with straight leg raising causing severe low back pain at 32 degrees. There is poor tolerance to Gaenselen's test and adaptive myofascial shortening on the hamstring. A magnetic resonance imaging scan done on 10/02/2013 showed Lumbar spine L4-S1 disc bulging, and bilateral foraminal stenosis. Current medications are: Norco 10/325mg, and Soma. The following diagnoses are applied: chronic low back pain multi-level disc bulging, lumbar foraminal stenosis, right sciatica, gait derangement, gout (non-industrial), and erectile dysfunction. A urine sample was unable to be obtained this visit. The plan of care noted the patient recommended using a transcutaneous nerve stimulator unit, topical analgesia cream, current medications and following up visit. By 03/17/2015 there were no changes to the subjective complaint, objective assessment, plan of care, treating diagnoses.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS (transcutaneous electrical nerve stimulation) Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain, pages 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 TENS Unit include 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. From the submitted reports, the patient has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive physical therapy, activity modifications, yet the patient has remained symptomatic and functionally impaired. There is no documentation on how or what TENS unit is requested, whether this is for rental or purchase, nor is there any documented short-term or long-term goals of treatment with the TENS unit. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the treatment already rendered for this chronic injury of 2008. The TENS (transcutaneous electrical nerve stimulation) Unit is not medically necessary and appropriate.

Scooter: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Knee & Leg chapter (Acute & Chronic) - Power Mobility Devices (PMDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs)- Scooter Page(s): 100.

Decision rationale: Per MTUS Guidelines regarding power mobility devices such as scooters, they are not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized scooter is not essential to care. The patient remains ambulatory and does not appear to be homebound. The criteria for the power mobility device has not been met from the submitted reports. There is no documented clinical motor or neurological deficits of the upper extremities to contradict the use of the single point cane. The Scooter is not medically necessary and appropriate.