

Case Number:	CM15-0200164		
Date Assigned:	10/15/2015	Date of Injury:	11/04/2011
Decision Date:	11/24/2015	UR Denial Date:	09/18/2015
Priority:	Standard	Application Received:	10/12/2015

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: Preventive Medicine, Occupational Medicine

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(n) 34 year old male, who sustained an industrial injury on 11-4-11. The injured worker was diagnosed as having lumbar sprain and thoracic sprain. Subjective findings (6-1-15, 7-28-15, 8-25-15) indicated ultrasound pre-treatment pain was 5-6 out of 10 and post treatment pain was 3-4 out of 10 in the lower back. Objective findings (6-1-15, 7-28-15, 8-11-15, 8-25-15) revealed decreased range of motion with forward flexion and extension and tenderness to palpation in the lumbar spine. As of the PR2 dated 9-9-15, the injured worker reports low back pain described as dull to sharp and radiating to the right lower extremity. He rates his pain ultrasound pre-treatment 5 out of 10 and post-treatment 3-4 out of 10. The treating physician noted that the injured worker has completed physical therapy and request for additional therapy has been denied. Objective findings include decreased range of motion with forward flexion and extension and tenderness to palpation in the lumbar spine. Treatment to date has included a TENS unit (since at least 5-18-15), physical therapy and acupuncture (number of sessions not provided), group psychotherapy, Cyclobenzaprine, Omeprazole and LidoPro cream. The Utilization Review dated 9-18-15, non-certified the request for retrospective 2 TENS patches for DOS 9-9-15 and retrospective 1 ultrasound treatment for DOS 9-9-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective 2 TENS patches for DOS 9/9/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The use of TENS for chronic pain is not recommended by the MTUS Guidelines as a primary treatment modality, but a one-month home-based TENS trial may be considered if used as an adjunct to a program of evidence-based functional restoration in certain conditions. A home based treatment trial of one month may be appropriate for neuropathic pain and CRPS II and for CRPS I. There is some evidence for use with neuropathic pain, including diabetic neuropathy and post-herpetic neuralgia. There is some evidence to support use with phantom limb pain. TENS may be a supplement to medical treatment in the management of spasticity in spinal cord injury. It may be useful in treating MS patients with pain and muscle spasm. The criteria for use of TENS include chronic intractable pain (for one of the conditions noted above) with documentation of pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, a one month trial period of the TENS unit should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used as well as outcomes in terms of pain relief and function, and a treatment plan including specific short and long term goals of treatment. In this case,, the injured worker has reportedly been using the TENS device since May-2015, without continued documentation or objective increases in function, therefore, it's continued use is not supported and there is no requirement for replenishment of supplies. The request for retrospective 2 TENS patches for DOS 9/9/15 is not medically necessary.

Retrospective 1 ultrasound treatment for DOS 9/9/15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Ultrasound, therapeutic.

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/Shock Wave Therapy Section.

Decision rationale: The MTUS Guidelines do not address the use of extracorporeal shock wave therapy to the lumbar spine. The ODG does not recommend the use of shock wave therapy as the available evidence does not support the effectiveness of ultrasound or shock wave for treating low back pain, therefore, the request for retrospective 1 ultrasound treatment for DOS 9/9/15 is not medically necessary.