

Case Number:	CM15-0049491		
Date Assigned:	03/23/2015	Date of Injury:	05/05/2000
Decision Date:	05/01/2015	UR Denial Date:	02/18/2015
Priority:	Standard	Application Received:	03/16/2015

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 44 year old male, who sustained an industrial injury on May 5, 2000. He reported low back pain and leg pain. The injured worker was diagnosed as having unspecified meningitis, unspecified neuralgia neuritis and radiculitis, fibromyalgia/myositis and arachnoiditis. Treatment to date has included TENS unit and medications. On November 18, 2014, the injured worker complained of chronic low back pain and leg pain due to his work related injury. He also complained of pain at his wrists. Physical examination of the lumbar spine revealed pain to palpation on both sides at the L3-S1 region. There was pain noted over the lumbar intervertebral spaces on palpation. Extension of the lumbar spine was noted to be 15 degrees and there was pain with lumbar extension. The treatment plan included medication, biobehavioral pain treatment followed by reevaluation and replacement of his damaged Orthostim3 device.

IMR ISSUES, DECISIONS AND RATIONALES

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

Batteries for Biostim I and F TENS unit for one year: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-121.

Decision rationale: The patient presents on 11/18/14 with unrated lower back and left leg pain. The patient's date of injury is 05/05/00. Patient has no documented surgical history directed at these complaints. The request is for batteries for Biostim I and f tens unit for one year. The RFA was not provided. Physical examination dated 11/18/14 reveals tenderness to palpation of the bilateral lumbar paraspinal muscles, lumbar facet pain from L3-S1 levels, and pain upon palpation of the lumbar intervertebral spaces. The patient is currently prescribed Baclofen, Colace, Klonopin, Prilosec, Soma, Oxycontin, Oxycodone, and Clonidine. Diagnostic imaging was not included. Patient is currently classified as permanent and stationary, is not working. MTUS Chronic Pain Medical Treatment Guidelines, pg114-121, Criteria for the use of TENS states: "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. For the conditions described below". The guideline states the conditions that TENS can be used for are: Neuropathic pain, Phantom limb pain and CRPS II, Spasticity, and Multiple sclerosis (MS). In this case, it is not clear why this patient requires a 1-year supply of batteries for his Biostim unit. Progress note dated 11/18/14 indicates that there is some sort of damage to this patient's device, though the nature of this damage is not clear. The same note does provide documentation of limited efficacy attributed to this device. However, no rationale is provided as to why this unit's battery is not charging or why repairs to the device cannot be undertaken. Furthermore, in the same progress note the treater expresses that he is seeking a total replacement of the device, meaning additional batteries are not required. Therefore, the request IS NOT medically necessary.

TENS unit supplies for one year: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-121.

Decision rationale: The patient presents on 11/18/14 with unrated lower back and left leg pain. The patient's date of injury is 05/05/00. Patient has no documented surgical history directed at these complaints. The request is for TENS unit supplies for one year. The RFA was not provided. Physical examination dated 11/18/14 reveals tenderness to palpation of the bilateral lumbar paraspinal muscles, lumbar facet pain from L3-S1 levels, and pain upon palpation of the lumbar intervertebral spaces. The patient is currently prescribed Baclofen, Colace, Klonopin, Prilosec, Soma, Oxycontin, Oxycodone, and Clonidine. Diagnostic imaging was not included. Patient is currently classified as permanent and stationary, is not working. MTUS Chronic Pain Medical Treatment Guidelines, pg114-121, Criteria for the use of TENS states: "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. For the conditions described below". The guideline states the conditions that TENS can be used for are: Neuropathic pain, Phantom limb pain and CRPS II, Spasticity, and Multiple sclerosis (MS). In this case, the treater is requesting one year of supplies for this patient's tens unit, though it is not clear exactly how many electrodes this patient requires for a year. Progress note dated 11/18/14 does document pain improvement attributed to this device. However, "a year of supplies" is an incomplete prescription as the supply needed is dependent on frequency of use, durability of the device and electrodes, care and maintenance, etc. Without clearer indication of the number of electrodes, conductive gels, or other supplies this patient requires for the year, the medical necessity cannot be substantiated. The request IS NOT medically necessary.

Belt clip replacement: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Chapter Knee & Leg and Title DME.

Decision rationale: The patient presents on 11/18/14 with unrated lower back and left leg pain. The patient's date of injury is 05/05/00. Patient has no documented surgical history directed at these complaints. The request is for belt clip replacement. The RFA was not provided. Physical examination dated 11/18/14 reveals tenderness to palpation of the bilateral lumbar paraspinal muscles, lumbar facet pain from L3-S1 levels, and pain upon palpation of the lumbar intervertebral spaces. The patient is currently prescribed Baclofen, Colace, Klonopin, Prilosec, Soma, Oxycontin, Oxycodone, and Clonidine. Diagnostic imaging was not included. Patient is currently classified as permanent and stationary, is not working. MTUS is silent on durable medical equipment of this nature. ODG guidelines, Chapter Knee & Leg and Title DME, states that "The term DME is defined as equipment which: (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. (CMS, 2005)" DME is "Recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below." In regard to the request for an unspecified belt clip replacement, treater has not provided a reason for the request or described exactly what is being requested. The request as written could be for this patient's wheel chair, or possibly a gait belt. It is not clear exactly what sort of belt clip this patient requires. Without a clearer rationale as to why this replacement clip is required, the medical necessity cannot be substantiated. In addition, ODG does not consider such a belt clip to be medical equipment, as it is not used to treat a specific illness. The request IS NOT medically necessary.