

Case Number:	CM15-0175479		
Date Assigned:	09/16/2015	Date of Injury:	09/03/2014
Decision Date:	10/19/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/05/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 45 year old male who sustained an industrial injury on 09-03-14. A review of the medical records indicates the injured worker is undergoing treatment for sprain and strain of the lumbar spine, right hip, and left knee, as well as right hip trochanteric bursitis. Medical records (07-27-152) reveal the injured worker complains of right hip and lower back pain rated at 7/10 and left knee pain rated at 2/10. The physical exam (07-27-15) reveals tenderness and spasm in the low back and tenderness in the right hip and left knee. Restricted range of motion is present in the lower back and left knee. Treatment has included medications and 19 sessions of physical therapy. The physical therapy is reported to decrease pain and tenderness, however pain ratings are unchanged from the last visit, with the exception of the knee pain which decreased from 3/10 on the prior visit to 2/10 on the date of exam. The original utilization review (08-18-15) noncertified the request for a Prime Dual Electrical stimulator (TENS-STIM) and a lumbar spine support.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prime Dual Electrical Stimulator (TENS-EMS): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Chronic pain TENS.

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

Decision rationale: The California chronic pain medical treatment guidelines section on transcutaneous electrical nerve stimulation states: TENS, chronic pain (transcutaneous electrical nerve stimulation): Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters, which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. (Carroll-Cochrane, 2001) Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. One problem with current studies is that many only evaluated single-dose treatment, which may not reflect the use of this modality in a clinical setting. Other problems include statistical methodology, small sample size, influence of placebo effect, and difficulty comparing the different outcomes that were measured. This treatment option is recommended as an adjunct to a program of evidence based functional restoration. In addition, there must be a 30-day trial with objective measurements of improvement. These criteria have not been met in the review of the provided clinical documentation and the request is not medically necessary.

Lumbar Spine Support: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care.

Decision rationale: The ACOEM chapter on low back complaints and treatment recommendations states: Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. This patient has chronic ongoing low back complaints. Per the ACOEM, lumbar supports have no lasting benefit outside of the acute phase of injury. This patient is well past the acute phase of injury and there is no documentation of acute flare up of chronic low back pain. Therefore, criteria for use of lumbar support per the ACOEM have not been met and the request is not medically necessary.