

Case Number:	CM15-0099777		
Date Assigned:	06/02/2015	Date of Injury:	11/09/2013
Decision Date:	07/08/2015	UR Denial Date:	05/18/2015
Priority:	Standard	Application Received:	05/26/2015

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: Arizona, Texas

Certification(s)/Specialty: Internal 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 41 year old male, who sustained an industrial injury on 11/9/13. The injured worker has complaints of low back and leg pain. The diagnoses have included lumbar herniated nucleus pulposus (HNP) and lumbar disc bulging. The documentation noted that the injured worker had restricted back motion on examination. Treatment to date has included magnetic resonance imaging (MRI) showed one level problem L5-S1 (sacroiliac) with collapse; electromyography/nerve conduction study showed lumbar disc bulging; norco and soma. The request was for retrospective multi stim unit plus supplies, five month rental; retrospective heat cold unit purchase and retrospective lumbar home exercise rehab kit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Multi Stim Unit plus supplies, five month rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy; Interferential Current Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-.26 Page(s): 114-116.

Decision rationale: According to the MTUS, the use of a transcutaneous electrical nerve stimulation (TENS) is 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. These conditions include neuropathic pain, Phantom limb pain and CRPSII, spasticity, and multiple sclerosis. In this case the patient is not enrolled in an evidence-based functional restoration program and doesn't have an accepted diagnosis per the MTUS. The request is not medically necessary.

Retrospective heat cold unit purchase: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-300.

Decision rationale: According to the ACOEM chapter on low back pain regarding heat/cold treatment, at-home local applications of cold in first few days of acute complaint; thereafter, applications of heat or cold is recommended. It further states that there is no benefit to have PT application of heat/cold over home application. The patient has chronic pain in the back. Either hot or cold application is recommended. The use of a heat/cold unit purchase is medically necessary.

Retrospective lumbar home exercise rehab kit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-.26 Page(s): 46-47.

Decision rationale: According to the MTUS exercise is recommended. There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated. In this case the documentation doesn't support that a specialized Lumbar home exercise rehab kit is medically necessary. The MTUS does not support any specific exercise over any other exercise regimen. The request is not medically necessary.