

Case Number:	CM13-0019348		
Date Assigned:	10/11/2013	Date of Injury:	09/13/1990
Decision Date:	01/09/2014	UR Denial Date:	08/19/2013
Priority:	Standard	Application Received:	09/03/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in internal medicine, has a subspecialty in pulmonary disease, and is licensed to practice in California. 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 physician 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/services.

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 patient is a 73-year-old with a reported date of injury on 09/13/1990. The patient had tenderness to palpation with spasm and restricted range of motion in the cervical, thoracic, and lumbar spines, tenderness to palpation in the bilateral shoulders with restricted range of motion, tenderness to palpation in the bilateral elbows with restricted range of motion, tenderness to palpation in the bilateral wrists with restricted range of motion, tenderness to palpation in the right knee with restricted range of motion, and tenderness to palpation in the bilateral ankles with restricted range of motion, moderate pain in the neck, mid/upper back, lower back, bilateral shoulders, bilateral elbows, bilateral wrists, right knee, and bilateral ankles. The patient had no spasms in the bilateral elbows, bilateral wrists, right knee, and bilateral ankles. The patient carried diagnoses of cervical spine sprain/strain with radiculitis, thoracic spine sprain/strain, lumbar spine sprain/strain with radiculitis, dorsal/lumbar myofascial pain syndrome, bilateral shoulder sprain/strain, status post right shoulder subacromial decompression and anterior acromioplasty on 03/18/2013, bilateral elbow and wrist sprain/strain, bilateral ankle sprain/strain, status post arthroscopic surgery, right knee, plantar fasciitis, depression, and insomnia. The provider's treatment plan included a request for 6 months of EMS supplies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Six months of EMS supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Transcutaneous Electrotherapy Section Page(s): 114-116.

Decision rationale: The Physician Reviewer's decision rationale: According to the Chronic Pain Medical Treatment Guidelines, the use of electrical stimulation for patients with neuropathic pain, CRPS II (chronic regional pain syndrome, level 2), Phantom limb pain, spasticity, and multiple sclerosis is recommended. The guidelines note criteria for the use of TENS (transcutaneous electrical nerve stimulation) include; chronic intractable pain (for the conditions noted above), documentation of pain of at least three months duration; there is 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; other ongoing pain treatment should also be documented during the trial period including medication usage; and a treatment plan including the specific short- and long-term goals of treatment. Within the provided documentation the patient was noted to have tenderness to palpation with spasm and restricted range of motion in the cervical, thoracic, and lumbar spines and tenderness to palpation without spasm with restricted range of motion in the bilateral shoulders, bilateral elbows, bilateral wrists, right knee, and bilateral ankles. Within the provided documentation, the requesting physician did not include an adequate documented assessment of the patient's objective functional condition in order to demonstrate objective functional deficits needing to be addressed with the use of electrical stimulation. Additionally, within the provided documentation the requesting physician's rationale for the request was unclear. The request for six months of EMS supplies is not medically necessary or appropriate. Disclaimer: MAXIMUS