

Case Number:	CM13-0024253		
Date Assigned:	06/06/2014	Date of Injury:	02/16/2011
Decision Date:	07/28/2014	UR Denial Date:	08/21/2013
Priority:	Standard	Application Received:	09/13/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation 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 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 55-year-old male who reported an injury 02/16/2011. The mechanism of injury was not provided within the medical records. The clinical note dated 10/15/2013 indicated the injured worker reported pain to the right shoulder and low back. The injured worker reported constant discomfort which he graded as mild to moderate to the right shoulder which he reported radiated into the biceps tendon. The injured worker reported his range of motion was painful. The injured worker reported popping and cracking with range of motion especially with above shoulder level activities. The injured worker reported constant midline and paraspinous discomfort, right side being the greatest, which he graded as moderate to severe. The injured worker reported intermittent radiation down the posterior aspect of the thigh to the level of the calf. He reported sharp electrical type pain that radiated into his lower back. The injured worker reported numbness and tingling that followed the same distribution of pain in the right lower extremity. He reported back pain that increased with bending, stooping, sitting longer than 15 minutes and standing for more than 15 minutes. On the physical exam, there was tenderness to palpation to the anterior aspect of the shoulder, tenderness to palpation of the paraspinous lumbosacral without spasms, there was guarding noted through the range of motion testing. Range of motion for flexion was 30/32/29, extension was 25/28/26, right lateral bend was 25/26/26, and left lateral bend was 25/24/26. The injured worker had a positive straight leg to 85 degrees on the right. The injured worker's diagnoses were lumbar spine strain, chronic lumbar spine and right shoulder strain secondary to trauma sustained continuously, and history of lumbar spine strain secondary to 2000 specific injury and prior continuous trauma from 08/29/1978 through 10/12/2000. The injured worker's prior treatments included diagnostic imaging, physical therapy, and medication management. The provider submitted requests for MEDS 4+ INF

stimulator for 3 months, electrodes 3 months supply, and conductive garment/lumbar. A request for authorization was not submitted for review to include a date the treatment was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

MEDS 4+INF Stimulator for 3 Months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS) chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, (ICS) Page(s): 118-119.

Decision rationale: The request for MEDS 4+INF stimulator for 3 months is not medically necessary. The California Chronic Pain Medical Treatment Guidelines state Meds 4 +INF stimulator is not recommended as an isolated intervention. The guidelines also state there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. Although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support interferential current stimulation for treatment of these conditions. In addition, the documentation submitted did not indicate the injured worker was back to work, in physical therapy at this time, or utilizing any other treatment modalities. Additionally, there is insufficient literature to support the use of this current stimulation for the back and shoulder pain. Furthermore, there was lack of documentation of quantified pain relief. Therefore, the request is not medically necessary.

Electrodes 3 Months Supply: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Conductive Garment - Lumbar: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.