

Case Number:	CM13-0048656		
Date Assigned:	12/27/2013	Date of Injury:	10/21/2011
Decision Date:	03/11/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	11/06/2013

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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. 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 patient is a 37-year-old male who reported an injury on 10/21/2011. The most recent clinical note dated 09/17/2013 is illegible; therefore, this reviewer will refer to the most recent clinical note before that one. The most recent clinical note dated 08/20/2013 revealed the patient's diagnoses included cervical disc disease, cervical radiculopathy per an EMG/NCV study, bilateral shoulder sprain and strain, and bilateral elbow sprain and strain. The patient complained of neck pain, which she states radiates to her bilateral upper extremities, as well as her hands and fingertips with numbness and tingling. The patient rates the pain 4/10 on the VAS, and states that the pain is described as sharp and throbbing. The patient's are hypersensitive with inflammation and pain. The patient received previous physical therapy to include massage, exercise, and ice packs. She received very little benefit from previous physical therapy. Objective findings upon examination revealed there was tenderness and spasm over the paraspinal musculature of the cervical spine, positive axial head compression bilaterally, positive Spurling's sign bilaterally, and no tenderness to palpation of the facet joints. There was noted cervical range of motion in flexion and extension. There was left shoulder pain over the acromioclavicular joint. Sensation was decreased along the bilateral C6 dermatomes. Muscle strength was 5/5 bilaterally to all muscle groups.

IMR ISSUES, DECISIONS AND RATIONALES

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

Reactivation OrthoStim unit 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117, 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119, 121.

Decision rationale: Per California MTUS Guidelines, it is stated that interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of the effectiveness, except in conjunction with recommended treatments including return to work, exercise, and medication, and limited evidence of improvement on those recommended treatments alone. California Guidelines also do not recommend an NMES for chronic pain. There is no documentation provided in the medical records suggestive that the patient is participating in any type of exercise program at this time. The request is for reactivation of OrthoStim unit 4, which is suggestive that the patient has previously used the requested service. Per California MTUS Guidelines, it is stated that a 1 month trial can be appropriate to permit the physician and physical medicine provide to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain, and evidence of medication reduction. There is no documentation of any increased functional improvement, less complaints of pain, or evidence of medication reduction provided in the medical record post the previous use of the requested service. As such, the medical necessity for the requested service cannot be determined, and the request for reactivation of OrthoStim unit 4 is non-certified.