

Case Number:	CM13-0051994		
Date Assigned:	12/27/2013	Date of Injury:	01/28/2013
Decision Date:	03/26/2014	UR Denial Date:	10/23/2013
Priority:	Standard	Application Received:	11/15/2013

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 Physical Medicine & 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 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:

This female sustained an injury on 1/28/13 while employed by [REDACTED]. Request under consideration include IF Electrical Muscle Stimulator. Report of 10/7/13 from provider noted review of previous 2/6/12 comprehensive pain management report from another provider. Medication listed only Vicodin with impression of low back injury and left lumbar radiculopathy; and left piriformis syndrome. There was a report of left L4 transforaminal select nerve root block on 5/17/12; EMG report noted left peroneal neuropathy; otherwise no radiculopathy impression. Report of 10/15/13 from provider noted low back pain. Exam showed tenderness to palpation, decreased painful range of motion. Medications list Gralise, Vicodin, Flexeril, and Ambien. Diagnoses include low back pain; lumbar sprain/strain. The appeal request for IF stimulator was non-certified on 10/23/13 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electrical Muscle Stimulator: 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 Page(s): 115-118.

Decision rationale: This female sustained an injury on 1/28/13 while employed by [REDACTED]. Request under consideration include IF Electrical Muscle Stimulator. Report of 10/7/13 from provider noted review of previous 2/6/12 comprehensive pain management report from another provider. Medication listed only Vicodin with impression of low back injury and left lumbar radiculopathy; and left piriformis syndrome. There was a report of left L4 transforaminal select nerve root block on 5/17/12; EMG report noted left peroneal neuropathy; otherwise no radiculopathy impression. Report of 10/15/13 from provider noted low back pain. Exam showed tenderness to palpation, decreased painful range of motion. Medications list Gralise, Doxepin, Vicodin, Flexeril, and Ambien. Diagnoses include low back pain; lumbar sprain/strain. The appeal request for IF stimulator was non-certified on 10/23/13 citing guidelines criteria and lack of medical necessity. Per guidelines, IF/Ortho Stim is not recommended as an isolated intervention, but a trial may be considered as a noninvasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS) which have not been demonstrated. There is no clinical exam documented with neurological deficits nor are there specifics of what subjective complaints, limitations in ADL, or failed attempts with previous conservative treatments to support for the electrical muscle stim unit, not recommended as a first-line approach. Submitted reports have not demonstrated having met these criteria and the patient is continuing with a HEP for this January 2013 injury of sprain/strain. The Electrical Muscle Stimulator is not medically necessary and appropriate.