

Case Number:	CM13-0056178		
Date Assigned:	12/30/2013	Date of Injury:	09/29/2013
Decision Date:	03/19/2014	UR Denial Date:	11/12/2013
Priority:	Standard	Application Received:	11/21/2013

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 and Emergency Medicine 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:

This patient is a 29 year-old with a date of injury of 09/29/13. The progress reports associated with the request for services, dated 10/15/13 and 11/04/13, identified subjective complaints of neck and shoulder pain. The objective findings included shoulder tenderness with decreased sensation in the C6 dermatome. An MRI on 10/31/13 showed impingement of the right shoulder with a supraspinatus tear and minimal spondylosis of C3 through C6. The diagnoses included right trapezius strain and partial rotator cuff tear. The treatment has included physical therapy and oral medications. An OrthoStim4 was requested on 10/31/13. A utilization review determination was rendered on 11/12/13 recommending non-certification of "Rental x 2 months Orthostim 4 unit and supplies".

IMR ISSUES, DECISIONS AND RATIONALES

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

OrthoStim4 unit and supplies rental for two months: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Galvanic Stimulation, Interferential Current Stimulation Section, NMES Section, TENS Transcutane.

Decision rationale: The OrthoStim4 is a type of transcutaneous electrotherapy, similar to TENS, but with multiple different electrical specifications. These include TENS, Interferential Current Stimulation (ICS) therapy, Galvanic Stimulation and Neuromuscular Electrical Stimulation (NMES). The California Medical Treatment Utilization Schedule (MTUS) states that TENS is not recommended for the back. For other conditions, a one month trial of transcutaneous therapy is considered appropriate if used as an adjunct to an evidence-based program of functional restoration. In this case, the OrthoStim4 unit is being requested for a type of pain not indicated for treatment. Also, multiple criteria noted have not been met. The Guidelines state that a one-month rather than two-month trial should be attempted. Last, the OrthoStim4 uses some modalities that are not recommended. Therefore, there is no documented medical necessity for an OrthoStim4 unit.