

Case Number:	CM13-0072094		
Date Assigned:	01/08/2014	Date of Injury:	05/03/2005
Decision Date:	08/29/2014	UR Denial Date:	12/07/2013
Priority:	Standard	Application Received:	12/30/2013

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 & Rehab, has a subspecialty in Pain Medicine and is licensed to practice in Texas & Oklahoma. 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 52-year-old female with a reported date of injury on 05/03/2005. The mechanism of injury was not submitted within the medical records. Her diagnoses were noted to include chronic lower back pain, status post anterior fusion to L4-5 and L5-S1, failed back surgery syndrome, and left L4 and L5 radiculopathy. The progress note dated 02/06/2014 revealed the injured worker reported her medication regimen was helping for pain control and there was no change with her back pain pattern, which was constant pain in the low and radicular pain down her leg. The physical examination of the back revealed tenderness to palpation across the low back with lumbar spine testing showing a decreased range of motion. The upper extremity examination revealed no significant areas of tenderness to palpation and normal range of motion was in the shoulders, elbows, wrists, and fingers. The neurological examination revealed no significant weakness, decreased sensation in the left L4-5 and S1 dermatomes. The deep tendon reflexes were not equal. The straight leg test raise was positive. The Request for Authorization form was not submitted within the medical records. The request was for a MEDS STIM. However, the provider's rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

MEDS STIM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MICROCURRENT ELECTRICAL STIMULATION (MENS DEVICES).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Microcurrent electrical stimulation Page(s): 120.

Decision rationale: The request for a MEDS STIM is not medically necessary. The MEDS STIM is not mentioned in the guidelines. However, a MENS device is. The California Chronic Pain Medical Treatment Guidelines do not recommend a microcurrent electrical stimulation device. Based on the available evidence conclusions cannot be made concerning the effect of the MENS on pain management and objective health outcomes. The MENS differs from TENS in that it uses a significantly reduced electrical stimulation. TENS blocks pain, while MENS acts on naturally occurring electrical impulses to decrease pain by stimulating the healing process. The guidelines do not recommend a MEDS STIM and therefore, it is not warranted. As such, the request is not medically necessary.