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| Case Number: | CM14-0001103 | | |
| Date Assigned: | 01/22/2014 | Date of Injury: | 10/23/2009 |
| Decision Date: | 06/19/2014 | UR Denial Date: | 12/10/2013 |
| Priority: | Standard | Application Received: | 01/03/2014 |

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:

This patient sustained an injury on 10/23/09 while employed by the [REDACTED]. Request(s) under consideration include Retrospective DOS: 11/1/2013: 50 Electrodes Per Pair, Retrospective DOS: 11/1/2013: 12 Replacement Batteries, and Retrospective DOS: 1/1/2013: 2 Lead Wires, Pair. Report of 7/8/13 from the provider noted the patient with continued neck pain with stiffness and limited movement without relief; and right shoulder pain s/p arthroscopy with weakness. Exam showed cervical spine has limited range of motion of extension 5 degrees and lateral rotation of 35 degrees; tenderness of paravertebral cervical spine and trapezius with mild spasm; right shoulder with limited motion and tenderness. Diagnoses include cervical spine radiculitis with myofasciitis r/o disc injury and s/p right shoulder arthroscopy. The patient has been deemed P&S. There are no reports submitted with request of 11/26/13 for electrical stimulator accessories. Request(s) for Retrospective DOS 11/1/2013: 50 Electrodes per pair, Retrospective DOS: 11/1/2013: 12 Replacement Batteries, and Retrospective DOS: 11/1/2013: 2 Lead Wires, pair were non-certified on 12/10/13 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:

RETROSPECTIVE DOS 11/1/2013: 50 ELECTRODES PER PAIR: 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): 114-118.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of Neurostim Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. It appears the patient has received extensive conservative treatment to include medications, modified work and rest, and physical therapy. There is no documentation on what transcutaneous unit is to be purchased, its functional improvement from treatment trial, nor is there any documented short-term or long-term goals of treatment with the unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the unspecified Unit. There is no evidence for change in work status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the physical therapy treatment already rendered. The Transcutaneous unit is not medically necessary and appropriate as continued use of unspecified Transcutaneous Electrotherapy unit has failed and is not supported, so are all associated supplies of electrodes, batteries, and lead wires. The Retrospective DOS: 11/1/2013: 50 Electrodes Per Pair are not medically necessary and appropriate.

RETROSPECTIVE DOS 11/1/2013: 12 REPLACEMENT BATTERIES: 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): 114-118.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of Neurostim Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. It appears the patient has received extensive conservative treatment to include medications, modified work and rest, and physical therapy. There is no documentation on what transcutaneous unit is to be purchased, its functional improvement from treatment trial, nor is there any documented short-term or long-term goals of treatment with the unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the unspecified Unit. There is no evidence for change in work status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the physical therapy treatment already rendered. The Transcutaneous unit is not medically necessary and appropriate as continued use of unspecified Transcutaneous Electrotherapy unit has failed

and is not supported, so are all associated supplies of electrodes, batteries, and lead wires. Retrospective DOS: 11/1/2013: 12 Replacement Batteries are not medically necessary and appropriate.

RETROSPECTIVE DOS 11/1/2013: 2 LEAD WIRES, PAIR: 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 CHRONIC PAIN MEDICAL TREATMENT GUIDELINES TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114-118.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of Neurostim Unit include trial in conjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. It appears the patient has received extensive conservative treatment to include medications, modified work and rest, and physical therapy. There is no documentation on what transcutaneous unit is to be purchased, its functional improvement from treatment trial, nor is there any documented short-term or long-term goals of treatment with the unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the unspecified Unit. There is no evidence for change in work status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the physical therapy treatment already rendered. The Transcutaneous unit is not medically necessary and appropriate as continued use of unspecified Transcutaneous Electrotherapy unit has failed and is not supported, so are all associated supplies of electrodes, batteries, and lead wires. The Retrospective DOS: 11/1/2013, 2 Lead Wires, Pair are not medically necessary and appropriate.