

Case Number:	CM14-0005145		
Date Assigned:	02/05/2014	Date of Injury:	08/25/2011
Decision Date:	06/20/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	01/14/2014

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 Orthopaedic Surgery 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 61-year-old female sustained an industrial injury on 8/25/11. The mechanism of injury is not documented. The 11/26/13 treating physician report cited right shoulder, arm and back pain. Right shoulder exam findings noted positive impingement test, biceps tendon tenderness, mild acromioclavicular joint pain, active abduction 160 degrees, passive abduction 180 degrees, and pain with resisted abduction. Lumbar exam findings documented paraspinal muscle tenderness, guarding, and spasms, flexion 40 degrees, extension 30 degrees, tight bilateral hamstrings, and decreased right L5 dermatomal sensation. The diagnosis was lumbar strain with right lower extremity radiculopathy, right shoulder bursitis with acromioclavicular joint pain, right cubital tunnel syndrome, right wrist strain, right breast contusion, right greater trochanteric bursitis, bilateral knee strain, head trauma, and depression. The treatment plan recommended consultation, right shoulder surgery and medications. A request for purchase of a walking cane and 30-day rental of a [REDACTED] Multi Stim unit was submitted. The 12/26/13 utilization review denied these requests for lack of medical necessity. There was no indication of any specific gait abnormality or lower extremity weakness to substantiate the need for a walking cane. The [REDACTED] Multi Stim unit was denied as it included neuromuscular electrical stimulation which is not supported by guidelines. The 12/16/13 treating physician report cited subjective complaints of grade 8/10 aching right shoulder pain and significant weakness and grade 8-9/10 low back pain. Shoulder pain was increased with repetitive activities, above shoulder level work, and with cold weather. The physical exam findings were unchanged. The treating physician reported the patient was seeing a cardiologist for cardiac problems and had not been cleared for her approved right shoulder surgery. Medications were beneficial and refilled, including Norco and Prilosec. There was no additional information regarding the walking care or stimulation unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

██████████ MULTI STIM UNIT RENTAL 30 DAYS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS - TRANSCUTANEOUS ELECTROTHERAPY, Page(s): 116-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Page(s): 114-121.

Decision rationale: Under consideration is a request for a ██████████ Multi Stim unit for 30 days rental. This unit provides three forms of therapy: TENS, interferential current, and neuromuscular electrical stimulation. The California MTUS guidelines for transcutaneous electrotherapy recommend a 30-day TENS unit trial for chronic intractable pain when there is evidence that other appropriate pain modalities had been tried and failed. Interferential current therapy is not recommended as an isolated intervention as there is no quality evidence of effectiveness. Neuromuscular electrical stimulation is not recommended as there is no evidence to support its use in chronic pain. Guideline criteria have not been met. There is no evidence that other pain modalities have been tried and failed. Medications significantly reduce symptoms. If one or more of the individual modalities provided by this multi-modality unit is not supported, then the unit as a whole is not supported. Guidelines do not support the use of NMES for chronic pain or interferential current as an isolated intervention. Therefore, this request for a ██████████ Multi Stim unit for 30 days rental is not medically necessary.

WALKING CANE PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 1015-1017. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Walking Aids.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee And Leg, Walking Aids.

Decision rationale: Under consideration is a request for purchase of a walking cane. The California MTUS guidelines are silent regarding walking canes for chronic cases. The Official Disability Guidelines recommend the use of walking aids as determined by disability, pain, and age-related impairments. There is no indication in the medical records of functional gait impairment or ambulation-limiting pain to support the medical necessity of a walking aid. Therefore, this request for purchase of a walking cane is not medically necessary.