

Case Number:	CM14-0019064		
Date Assigned:	04/23/2014	Date of Injury:	08/01/2012
Decision Date:	07/07/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	02/14/2014

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 Occupational Medicine 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:

The patient is a 52-year-old female who has submitted a claim for Right Shoulder Rotator Cuff Deficiency with Impingement Syndrome, Cervical Strain, Right Hip Greater Trochanteric Bursitis, and History of Chest Wall Contusion, associated with an industrial injury date of August 1, 2012. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of severe right shoulder pain with limited strength and motion. She also complained of persistent pain with pressure over her hip. On physical examination, there was tenderness over the right greater trochanter, right shoulder, biceps tendon, and paracervical area. There was crepitus noted with active shoulder motion. There was limited range of motion with guarding of the right shoulder. Ulnar and median nerve provocative testing was negative. Hip motion was unrestricted. Treatment to date has included medications, occupational therapy, right shoulder injection, and right hip injection. Utilization review from January 16, 2014 denied the request for rental of ART-D Neuromuscular Stimulator for 3 months home use and a conductive garment because guidelines do not support the use of a neuromuscular stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

ART-D NEUROMUSCULAR STIMULATOR FOR HOME USE, RENTAL FOR 3 MONTHS: 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 page 121 Page(s): 121.

Decision rationale: According to page 121 of the CA MTUS Chronic Pain Medical Treatment Guidelines, neuromuscular electrical stimulation (NMES) devices are not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. In this case, the medical records failed to provide a rationale for NMES use despite not being recommended by guidelines. Therefore, the request for Art-D Neuromuscular Stimulator For Home Use, Rental For 3 Months is not medically necessary.

CONDUCTIVE GARMENT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.