MAXIMUS Federal Services

Case Number:	CM14-0110001		
Date Assigned:	09/19/2014	Date of Injury:	02/07/2014
Decision Date:	10/17/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	07/15/2014

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 Family 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:

This a 53-year-old male who reported an industrial injury on 2/7/2014, eight (8) months ago, attributed to the performance of his usual and customary job tasks reported as a motor vehicle accident. The patient complains of left shoulder pain. The patient is been treated with medications, steroid injection in the use of a sling. The patient is prescribed tramadol. X-rays of the left shoulder documented acromioclavicular and glenohumeral joint moderate degeneration; x-ray of the cervical spine documented multilevel degenerative disc disease of the thoracic spine; x-ray of the abdomen documented metallic bullet fragments and degenerative changes to the lumbosacral spine. The MRI of the shoulder dated 2/22/2014, documented moderate tendinosis of the supraspinatus tendon; apparent mild to moderate partial-thickness tearing along the articular surface near the muscle tenderness junction; mild tendinosis of the subscapularis tendon; no full thickness rotator cuff tear identified; tear of the long head of the biceps tendon proximally; mild to moderate condescending within the glenohumeral joint associated with marginal osteophytes formation; effusion; tearing along the base of the superior labrum and fraying of the posterior labrum; moderate degenerative changes of the AC joint with inferior spurring. The objective findings on examination included hypertonicity in the paracervical, suboccipital, and upper trapezius muscles; 2+ tenderness in the anterior, middle, and posterior regions of the left shoulder; range of motion of the shoulder was slightly decreased; lumbar spine range of motion was slightly diminished. The treatment plan included a orthopedic consultation for the shoulder; a [redacted] multi stim unit for five month rental with eight pairs of electrodes per month, lead wires #2 with adapter and an [redacted] back brace purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

[redacted] Multi Stim unit, 8 pairs of electrodes per month , lead wires #2, adaptor, back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 116, 118,121.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,Chronic Pain Treatment Guidelines transcutaneous electrotherapy; interferential current stimulation Page(s): 115; 118-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) lower back chapter-interferential therapy; pain chapter-interferential current stimulation

Decision rationale: The use of the [redacted] Multi Stim unit, 8 pairs of electrodes per month, lead wires #2, adaptor, back was not demonstrated to be medically necessary for the treatment of the lumbar spine eight (8) months status post MVA. The patient has chronic low back pain with lumbar spine DDD; however, the [redacted] Multi Stim unit, 8 pairs of electrodes per month, lead wires #2, adaptor, back is not recommended over the TENS unit. The 4-Lead TENS unit is not recommended by the CA MTUS over the use of the 2-Lead TENS unit. There is no demonstrated medical necessity for the prescription of the [redacted] Multi Stim unit, 8 pairs of electrodes per month, lead wires #2, adaptor, and back for the treatment of chronic low back pain. The [redacted] Multi Stim unit, 8 pairs of electrodes per month, lead wires #2, adaptor, back is a proprietary device that utilizes a unique electrical signal to deliver monophasic, peaked impulses directly to the site of application. The requested [redacted] Multi-Stim and supplies is a multiple channel stimulator that is reported by the vendor to alternate between the use of neuromuscular stimulation for strengthening and interferential stimulations for pain relief. The NMES was requested to treat the chronic back pain secondary to lumbar DDD 8 month's s/p MVA. Evidence based guidelines do not support the use of NMES or interferential muscle stimulation for the treatment of the chronic low back pain. Since the NMES is a multiple channel stimulator and the NMES and Interferential muscle stimulation components are not recommended by evidence-based guidelines, then the whole devise is not recommended or considered to be medically necessary or reasonable for the treatment of chronic low back pain. The use of a neuromuscular stimulator for the reduction of pain or control spasms is not demonstrated to be medically necessary/reasonable or meet the criteria recommended by the currently accepted evidence-based guidelines. The use of a neuromuscular electrical stimulation (NMES) devise with the two wave forms of NMES and Interferential muscle stimulation for chronic lower back pain. The treating physician provided no subjective/objective evidence to support the medical necessity of the for the treatment of the patient's chronic low back pain over the prescription of the recommended TENS unit. The treating physician has provided no rationale supported with objective evidence to support the medical necessity of the [redacted] Multi Stim unit, 8 pairs of electrodes per month, lead wires #2, adaptor, back and override the recommendations of the California MTUS. The prescription for the [redacted] Multi Stim unit, 8 pairs of electrodes per month, lead wires #2, adaptor, back by the requesting physician is not accompanied with a rationale or objective evidence to support medical necessity.

[redacted] **back brace purchase:** Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) back chapter-lumbar supports; back brace postoperative

Decision rationale: The patient is eight (8) months s/p DOI and there is no medical necessity for the requested lumbosacral orthosis or back brace for the treatment of the effects of the industrial injury. There were no stated subjective or objective findings related to the lumbar spine to support the medical necessity of the requested [redacted] lumbar support or LSO lumbar brace. The patient was documented to have only TTP and reported decreased ROM to the lumbar spine. It was no documented radiculopathy. The provider failed to provide any clinical documentation with objective findings documented to support medical necessity such as instability to the lumbar spine. There were no changes in the clinical status of the patient that would meet the recommended criteria for the use of lumbar supports. There was no objective evidence to support the medical necessity of the requested lumbar-sacral back brace/support directed to the lumbar spine. There was no demonstrated medical necessity for the requested L/S support or corset for the cited objective findings on examination. There is no rationale to support the medical necessity of the replacement lumbar support in relation to the effects of the industrial injury. The back brace is not recommended for the cited diagnoses. The criteria recommended by evidence based guidelines are not documented. The requested lumbar support is not recommended by the CA MTUS or the Official Disability Guidelines (ODG) in favor of more active rehabilitation to the lower back. There is no clinical documentation of treatment directed to spondylolisthesis, documented instability, or post-operative treatment (fusion) for which the back brace would be recommended by the ODG. The prescribed lumbar support was not demonstrated to be medically necessary or reasonable for the treatment of the effects of the industrial injury. There was no subjective/objective clinical evidence provided that demonstrated the medical necessity for the prescribed back brace for the treatment of the lower back. The current evidence based guideline treatment recommendations favor active rehabilitation and exercise over the use of lumbar supports/corsets. There is no demonstrated medical necessity for the prescribed [redacted] back brace purchase.