

Case Number:	CM14-0138889		
Date Assigned:	09/05/2014	Date of Injury:	06/04/2013
Decision Date:	10/14/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	08/27/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 61 year old male whose date of injury is 06/04/13. The mechanism of injury is described as cumulative trauma. Diagnoses are internal derangement right knee, herniated nucleus pulposus cervical, left upper extremity cervical radiculopathy, musculoligamentous injury bilateral shoulders left greater than right, bilateral AC arthrosis, left lateral epicondylitis elbow, radiculopathy left lower extremity, rule out bilateral hip joint internal derangement, musculoligamentous injury bilateral knees, internal derangement left knee, lumbar intervertebral disc disease syndrome, lumbar radiculopathy and left wrist TFCC tear. Treatment to date includes physical therapy. Note dated 07/29/14 indicates that there is tenderness to palpation and muscle spasm in the cervical and lumbar paravertebrals and reduced range of motion of the cervical and lumbar spines. The injured worker underwent left wrist arthroscopy on 06/27/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

multistimulation unit rental for 5 months: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301, Chronic Pain Treatment Guidelines Exercise, TENS (Transcutaneous Electric Nerve Stimulation), Inter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Transcutaneous electrotherapy Page(s): 114-117.

Decision rationale: Based on the clinical information provided, the request for solace multistimulation unit rental for 5 months is not recommended as medically necessary. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no indication that the injured worker has undergone a successful one month trial of the unit as required by MTUS guidelines to establish efficacy of treatment. There are no specific, time-limited treatment goals provided. Therefore, [REDACTED] multi-stimulation unit rental for 5 months is not medically necessary.