

Case Number:	CM14-0174136		
Date Assigned:	10/28/2014	Date of Injury:	03/27/2006
Decision Date:	12/04/2014	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	10/22/2014

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 & Rehabilitation and is licensed to practice in Illinois. 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 53-year-old male who reported an injury on 03/27/2006. The mechanism of injury was not submitted for review. The injured worker has diagnoses of right shoulder status post rotator cuff repair, lumbar sprain/strain with herniated nucleus pulposus, cervical sprain/strain, anxiety/depressed mood, left shoulder impingement, obesity, status post left shoulder arthroscopic decompression and hardware removal of the lumbar spine. Past medical treatment consists of surgery, physical therapy, X-Force stimulation and medication therapy. Medications consist of Flexeril, Norco, Prilosec, Xanax, Naprosyn, topical cream of ketoprofen, gabapentin and tramadol. No diagnostics were submitted for review. On 07/31/2014, the injured worker complained of severe back pain. Examination of the back revealed a flexion of only 40 degrees. Motor and sensory were slightly decreased in the lower extremities. Straight leg raise sitting was +80 bilaterally. Straight leg raise lying was +50 degrees bilaterally. Medical treatment plan was for the injured worker to continue with the X-Force stimulator unit. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-Force Stimulator Unit with 3 Months of Supplies and 2 Conductive Garments: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Transcutaneous Electrotherapy X-Force Stimulator Page(s): 116.

Decision rationale: The request for X-Force Stimulator Unit with 3 Months of Supplies and 2 Conductive Garments is not medically necessary. There was a lack of documentation indicating significant deficits upon physical exam. The efficacy of the injured worker's previous course of conservative care was not provided. It was also unclear if the injured worker underwent an adequate trial. The request does not specify if the injured worker needed to rent or purchase the X-Force stimulator unit. Additionally, there was no indication in the submitted documentation of the efficacy of the unit. It was mentioned that the injured worker had been using the X-Force stimulator. However, there was no mention as to whether it was helping with any functional deficits, pain levels or activities of daily living improvements. Given the above, the injured worker is not within the recommended guideline criteria. As such, the request is not medically necessary.