

Case Number:	CM14-0025759		
Date Assigned:	06/13/2014	Date of Injury:	06/25/2013
Decision Date:	07/15/2014	UR Denial Date:	02/28/2014
Priority:	Standard	Application Received:	02/28/2014

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, 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 51 year old male who reported and injury on 06/25/2013 (which was not reported until 12/19/2013) to a fall. The claimant had a history of mid back pain, 9/10 the presents as a "pushing out of back" feeling, constantly. It is noted that the patient is not eating and lost 16 pounds. Low back pain is reported to be 4-5/10, occasional right arm weakness, and denied lower extremity radicular symptoms. Upon examination on 01/30/2014 range of motion; flexion 90/90 degrees, extension 5/30 degrees, right lateral flexion 25/25 degrees, left lateral flexion 20.25 degrees, right rotation 15/25 degrees, left rotation 20/25 degrees. There was pain in extension, left lateral flexion and left rotation 4+ right paravertebral spasm, mild thoracic, moderate point tenderness T5-6 and T8-9 spinous process. There was tenderness over anterior right 6th rib. The straight leg raise was negative. Motor reflexes and sensory were intact. The claimant had uncontrollable mild tremors of the upper and lower extremities ("pain response") and mild diffusion lumbosacral tenderness. Upon examination on 04/2/2014 the claimant had low back pain described as "like stress" 4-5/10, mid back pain 9/10 constant, constant shaking, and occasional right arm weakness. The low back pain was markedly improved. Doros lumbar spine range of motion revealed, flexion 90/90 degrees, extension 5/25 degrees, right lateral flexion 25/25 degrees, left lateral flexion 20/25 degrees, left rotation 20/25 degrees, and right rotation 15/25 degrees. marked pain on extension and left lateral flexion as well as moderate pain on right rotation, 4+ spasm in the right parathoracis region with point tenderness at the T5/6 vertebral level as weak as T8 and T9, moderate tenderness extending around the 6th rib as well 1-2+ tenderness diffusely across the lumbar junction, and the straight leg raise is negative. The claimant was unable to do heel or toe walk due to pain. Diagnoses included thoracic compression fracture, thoracic sprain/strain, lumbosacral strain/sprain, status post fall from ladder, and chronic myofascial pain syndrome. The treatment received were CT scan on 12/9/13

compression fracture, on 12/23/12 in emergency room for increased pain and inability to sleep and approximately 10 sessions of chiropractic treatments starting 02/10/2014. The medications include ibuprofen and valium. The treatment plan includes purchase of a conductive garment to be used with the ARTD Neuromuscular stimulator and the purchase of electrodes monthly for the ARTD Neuromuscular stimulator. The request for authorization form was not provided within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

THE PURCHASE OF A CONDUCTIVE GARMENT TO BE USED WITH THE ARTD NEUROMUSCULAR STIMULATOR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation.

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.

THE PURCHASE OF ELECTRODES MONTHLY FOR THE ARTD NEUROMUSCULAR STIMULATOR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation.

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.

RENTAL OF AN ARTD NEUROMUSCULAR STIMULATOR FOR THREE MONTHS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) guidelines state that the neuromuscular electrical stimulation (NMES devices) is 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 to suggest benefit from NMES for chronic pain. In this case, the claimant has history of back pain. There is no justification to

establish medical necessity for requested device. Additionally, there is no clinical condition that would correspond with the use of device. As such, the request rental of an ARTD neuromuscular stimulator for three months is not medically necessary and appropriate.