MAXIMUS Federal Services

Case Number:	CM14-0029788		
Date Assigned:	06/20/2014	Date of Injury:	10/04/2009
Decision Date:	07/17/2014	UR Denial Date:	02/21/2014
Priority:	Standard	Application Received:	03/10/2014

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 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 Injured worker is a 60-year-old female whose date of injury is 10/4/09. The injured worker complains of neck pain and right sided lower back pain with leg radiation. She is noted to have severe pain over the mid cervical region, over L4-5, L5-S1 facet joints, and right SI joint. Neurological exam was normal. She is diagnosed with sprain / strain of Lumbosacral spine, cervicalgia, myalgia. She has received comprehensive conservative management including physical therapy, multiple medications and diagnostic testing. The request for right sacroilliac joint injection is noted. She underwent right L5-S1 TF-ESI on 5/6/14. She has also received 20 physical therapy visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

A trial of the RS-41 Interferential and Muscle Stimulator, for a duration of 1 month: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG).

Decision rationale: The medical records do not indicate the request is for an initial one-month trial of electrotherapy in conjunction with the current treatment plan, along with weaning of medication in an effort to support full return to work ability. Therefore, the medical necessity of the requested device is not established. The California Medical Treating Utilization Schedule Guidelines Chronic Pain Medical Treatment Guidelines criteria for NMES device considers its use primarily as part of a rehabilitation program following stroke associated with leg weakness and inability to ambulate. There is no evidence to support its use in chronic pain however. Therefore, the medical necessity of the requested device is not established and is therefore not medically necessary.