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| Case Number: | CM14-0033350 | | |
| Date Assigned: | 06/20/2014 | Date of Injury: | 11/09/2005 |
| Decision Date: | 07/24/2014 | UR Denial Date: | 03/05/2014 |
| Priority: | Standard | Application Received: | 03/17/2014 |

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 American Board of Neurological Surgery 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 55-year-old female who was reportedly injured on 11/9/2005. The mechanism of injury was not listed in the records reviewed. The most recent progress note dated 2/14/2014, indicates that there were ongoing complaints of low back pain. The physical examination was handwritten and partially illegible. There was a determination that the patient had low back pain with bilateral straight leg raise. No recent diagnostic studies were available for review. Previous treatment included Ativan and Motrin. A request was made for Ativan 1 mg # 30, and OrthoStim 4 Unit for one (1) month rental and was not certified in the pre-authorization process on 3/5/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

OrthoStim 4 Unit for one (1) month rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Interferential Current Stimulation (ICS), Neuromuscular Electrical Stimulation (NMES Devices), Galvanic Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 2009, Neuromuscular Electrical Stimulation (NMES Devices) Page(s): 121 of 127.

Decision rationale: After review of the medical documentation provided, it was noted the 55-year-old injured worker does have chronic back pain from a work-related injury in 2005. The medical documentation provided was handwritten and partially illegible. There were no findings to identify any objective clinical findings that could support the use of this request. After reviewing CA MTUS guidelines, it is noted that neuromuscular stimulation was used primarily as part of the rehabilitation program following stroke, and there was no evidence to support its use in chronic pain. Therefore, the request for this device is deemed not medically necessary.