

Case Number:	CM14-0040645		
Date Assigned:	06/27/2014	Date of Injury:	05/23/1997
Decision Date:	07/28/2014	UR Denial Date:	03/07/2014
Priority:	Standard	Application Received:	04/04/2014

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 and Rehabilitation, has a subspecialty in Pain Management 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:

This is a female patient with the date of injury of May 23, 1997. A progress report dated February 11, 2014 identifies current complaints of lower back pain, altered feeling or sensation in the thigh and knee area and tops of feet, and neck pain that occasionally radiates to the left upper extremity. The physical examination identifies mild muscle spasm and tenderness of paracervical muscles. Decreased cervical range of motion. Palpation of paralumbar muscles showed moderate muscle spasm or tightness. Decreased lumbar range of motion. Sensation is decreased on the tops of both feet bilaterally to light touch, pinprick and vibration. There is altered sensation noted in both anterior lateral thighs and knee area. Diagnoses identified includes chronic low back pain residuals of two lumbar surgeries and cervical strain with intermittent radicular symptoms to the left upper extremity. The recommendation identifies authorize supplies for muscle stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Supplies for muscle stimulator for lower back pain an outpatient: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Chronic Pain Page(s): 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

Decision rationale: Regarding the request for 1 supply of muscle stimulator for lower back pain as an outpatient, the guidelines state that neuromuscular electrical stimulation is not recommended. As such, the currently requested 1 supply of muscle stimulator for lower back pain as an outpatient is not medically necessary.