

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0055329 | | |
| Date Assigned: | 07/07/2014 | Date of Injury: | 10/27/2008 |
| Decision Date: | 09/05/2014 | UR Denial Date: | 04/21/2014 |
| Priority: | Standard | Application Received: | 04/24/2014 |

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 Family Medicine and is licensed to practice in Arizona. 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 patient is a 67 year old female with a date of injury on 10/27/2008. Subjective complaints are of increased left shoulder pain with limited motion and weakness. Physical exam shows decreased range of motion in the shoulder. Medications include Relafen, Cyclobenzaprine, Hydrocodone/APAP, Advil, and Omeprazole. Submitted hand written office records are largely illegible. Request is for a two month rental of an Orthostim unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Orthostim4 unit with thermaphore 2 months rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-122.

Decision rationale: The California MTUS guidelines do not support interferential current stimulation as an isolated intervention. Quality evidence of efficacy is limited even in conjunction with treatments, including return to work, exercise and medications. A TENS (Transcutaneous electrical nerve stimulation) unit is only recommended for a one month trial in conjunction with other modalities. Galvanic stimulation and neuromuscular stimulation is not

supported by current guidelines. The requested device includes NMES and galvanic stimulation, and if these components of a unit are not supported, there is lack of support for the whole unit. Due to these reasons, the Home Orthostim unit with Thermaphore unit is not medically necessary.