

Case Number:	CM14-0057347		
Date Assigned:	07/09/2014	Date of Injury:	04/06/2012
Decision Date:	08/29/2014	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	04/28/2014

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 Family Medicine, and is licensed to practice in North Carolina. 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 patient with a 4/6/12 date of injury. The patient's date of birth was not provided in the records reviewed. The mechanism of injury was when he tripped and fell in a manhole, causing injuries to his left hip, back, head, and left upper extremities. According to a 9/14/13 agreed medical examination report, the patient complained of low back pain, present always, with pain radiation to the left buttock, leg, and foot. He also had mid and upper back pain. He also had left shoulder pain and neck pain, present sometimes. He also complained of periodic headaches that were increased by neck pain. Objective findings: pain while assessing lumbar ROM (range of motion) during the motion phase or at end range, decreased ROM of lumbar and cervical spine, sensation intact throughout upper and lower extremities, normal motor exam, no tenderness to palpation of lumbar spine or cervical spine. Diagnostic impression: chronic lumbosacral musculoligamentous strain with facet arthropathy, chronic cervicothoracic musculoligamentous strain. Treatment to date: medication management, activity modification, physical therapy. A UR decision dated 4/18/14 denied the requests for Electrode gel 2 PR sensaderm non-sterile SQ TIP, Battery power pack 4.5 volt (1 ct), and Adhesive remover wipe 01/ Mint scented. Documentation does not contain a detailed legible rationale describing why these items are needed or describing patients response with the use of the OrthoStim to the support for continued associated supplies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electrode gel 2 PR sensaderm non-sterile SQ TIP(date of service 02/27/2014-03/28/2014): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 114-116.

Decision rationale: The OrthoStim 4 unit incorporates interferential, TENS, NMS/EMS, and galvanic therapies into one unit. However, there is no documentation of a rationale identifying why a combined electrotherapy unit would be required as opposed to a TENS unit. In addition, CA MTUS does not consistently recommend interferential, NMS, and galvanic electrotherapy. According to the UR decision dated 4/18/14, this request is for OrthoStim supplies. However, guidelines do not support the use of OrthoStim, a multimodality neuromuscular stimulator unit, and subsequently do not support supplies for the unit. In addition, there is no documentation of functional improvement from the patient's use of the OrthoStim unit. Therefore, the request for Electrode gel 2 PR sensaderm non-sterile SQ TIP (date of service 02/27/2014-03/28/2014) is not medically necessary.

Battery power pack 4.5 volt (1 ct)(date of service 02/27/2014-03/28/2014): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 114-116.

Decision rationale: The OrthoStim 4 unit incorporates interferential, TENS, NMS/EMS, and galvanic therapies into one unit. However, there is no documentation of a rationale identifying why a combined electrotherapy unit would be required as opposed to a TENS unit. In addition, CA MTUS does not consistently recommend interferential, NMS, and galvanic electrotherapy. According to the UR decision dated 4/18/14, this request is for OrthoStim supplies. However, guidelines do not support the use of OrthoStim, a multimodality neuromuscular stimulator unit, and subsequently do not support supplies for the unit. In addition, there is no documentation of functional improvement from the patient's use of the OrthoStim unit. Therefore, the request for Battery power pack 4.5 volt (1 ct) (date of service 02/27/2014-03/28/2014) is not medically necessary.

Adhesive remover wipe 01/ Mint scente(date of service 02/27/2014-03/28/2014): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 114-116.

Decision rationale: The OrthoStim 4 unit incorporates interferential, TENS, NMS/EMS, and galvanic therapies into one unit. However, there is no documentation of a rationale identifying why a combined electrotherapy unit would be required as opposed to a TENS unit. In addition, CA MTUS does not consistently recommend interferential, NMS, and galvanic electrotherapy. According to the UR decision dated 4/18/14, this request is for OrthoStim supplies. However, guidelines do not support the use of OrthoStim, a multimodality neuromuscular stimulator unit, and subsequently do not support supplies for the unit. In addition, there is no documentation of functional improvement from the patient's use of the OrthoStim unit. Therefore, the request for Adhesive remover wipe 01/ Mint scented (date of service 02/27/2014-03/28/2014) is not medically necessary.