

Case Number:	CM14-0188123		
Date Assigned:	11/18/2014	Date of Injury:	07/02/2014
Decision Date:	04/07/2015	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	11/12/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

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 43-year-old male, who sustained an industrial injury on 7/2/2014. He has reported low back pain with radiation to right lower extremity. The diagnoses have included thoracic sprain, muscle spasm, thoracic/lumbosacral neuritis/radiculitis non-specified. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), analgesic, physical therapy, chiropractic therapy, and home exercises. Currently, the IW complains of pain to right side low back with pain and weakness in right lower extremity rated 6/10 VAS. Physical examination from 9/9/14 documented muscle tightness, Range of Motion (ROM) with guarding, diminished sensation, positive Gaenslen's test and Milgram's tests. The plan of care included continuation of chiropractic treatment, home exercise, electromyogram tests and requested authorization for a Home electrical muscle stimulation unit and supplies. On 10/16/2014 Utilization Review non-certified a Home electrical muscle stimulation unit for purchase, two packages of stimulator pads per month (four (4) pads each, one 9 volt battery every three months, home biofreeze gel 4 ounces one per month with three refills, three tubes total, to treat lumbar spine, thoracic spine and right leg symptoms. The MTUS and ODG Guidelines were cited. On 11/12/2014, the injured worker submitted an application for IMR for review of Home electrical muscle stimulation unit for purchase, two packages of stimulator pads per month (four (4) pads each, one 9 volt battery every three months, home biofreeze gel 4 ounces one per month with three refills, three tubes total, to treat lumbar spine, thoracic spine and right leg symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

One home electrical muscle stimulation unit purchase; two packages of stim pads per month (4 pads each); one 9 volt battery every three months; home Biofreeze gel, 4 ounces, once per month for three months, three tubes total: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 114-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Electrical stimulation Units.

Decision rationale: The CA MTUS and the ODG guidelines recommend that cutaneous electrical stimulation devices can be utilized for the treatment of musculoskeletal pain. The use of muscle stimulation devices can be incorporated during supervised physical therapy (PT) or during post surgical rehabilitation. The records indicate that the patient completed several series of PT, chiropractic treatments and home exercise program. The guidelines recommend maintenance treatments with home exercise program after completion of supervised physical treatments. Long term use of muscle stimulation treatment had not been established to have a sustained efficacy in the management of chronic musculoskeletal pain. Biofreeze if available over the counter and does not require prescription. The criteria for the purchase of one home electrical muscle stimulation unit, two packages of stim pads per month (4 pads each), one 9 volt battery every three months, home Biofreeze gel-4ounces once per month for three months-3 tubes total was not met.