

Case Number:	CM14-0203305		
Date Assigned:	12/15/2014	Date of Injury:	08/01/2007
Decision Date:	02/06/2015	UR Denial Date:	11/19/2014
Priority:	Standard	Application Received:	12/04/2014

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 Rehabilitation 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 patient is a 44-year old female with date of injury 08/01/07. The treating physician report dated 10/30/14 (61) indicates that the patient presents with low back pain and radicular pain. The physical examination findings reveal radicular pain in claimant's left leg. Her pain is rated a 6/10. Claimant also demonstrates limited range of motion in all vectors. Prior treatment history includes inter-body fusions at the L4-5 and L5-S1 levels with pedicle screw fixation. The current diagnosis is: - Discogenic syndrome lumbar. The utilization review report dated 11/19/14 denied the request for Electrical stimulation trial based on MTUS.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electrical stimulation trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The patient presents with low back pain and radicular pain. The physical examination findings reveal radicular pain in claimant's left leg. Her pain is rated a 6/10. Claimant also demonstrates limited range of motion in all vectors. The current request is for

Electrical stimulation trial. The treating physician report dated 10/30/14 states, patient "determined to get back to work, requesting functional restoration program consult ... Also request for T Electric Stim Trial." However, the type of electrical stimulation device is not discussed. Assumption is, the physician was referring to a neuromuscular electrical stimulation device. When discussing Neuromuscular electrical stimulation devices, MTUS guidelines state "Not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain." In this case the treating physician has not documented what type of electrical stimulation device is being proposed and if we are to infer it is a neuromuscular electrical stimulation device MTUS guidelines do not support this therapy. Therefore, the requested treatment is not medically necessary and appropriate.