

Case Number:	CM14-0209149		
Date Assigned:	01/13/2015	Date of Injury:	02/07/2014
Decision Date:	02/19/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	12/15/2014

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: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabn

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 27-year-old male who reported an injury on 02/07/2014. The mechanism of injury was a fall. His diagnoses include thoracic spine disc protrusion, lumbar spine multilevel disc herniation, and CHT with loss of consciousness with residuals. Past treatment was noted to include medications, therapy, and lumbar spine brace. On 10/16/2014, it was noted that the injured worker had mild to moderate upper back and lower back pain which he rated 5/10. He reported that his pain was relieved with medication and therapy. Upon physical examination, it was noted the injured worker had tenderness and spasm to the bilateral paraspinals and bilateral gluteal muscles. It was indicated that his range of motion was increased in all planes. His medications were not provided for review. The treatment plan was noted to include chiropractic therapy, acupuncture, medications, neurologist consult, and a urinalysis. A request was received for (6) localized intense Neurostimulation Therapy without a rationale. The Request for Authorization was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

(6) Localized Intense Neurostimulation Therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back; Lumbar & Thoracic (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Microcurrent electrical stimulation (MENS devices) Page(s): 120.

Decision rationale: The request for (6) localized intense neurostimulation therapy is not medically necessary. According to the California MTUS Chronic Pain Medical Treatment Guidelines, microcurrent electrical stimulation (MENS) is not recommended as there is a lack of available evidence indicating pain management and objective health outcomes from the use of this device. As this device is not recommended by the evidence based guidelines, the request is not supported. As such, the request for (6) localized intense neurostimulation therapy is not medically necessary.