

Case Number:	CM15-0100952		
Date Assigned:	06/03/2015	Date of Injury:	11/30/2009
Decision Date:	07/09/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	05/26/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 56-year-old, female who sustained a work related injury on 11/30/09. She was lifting heavy linen bags and injured her neck, upper back, both shoulders and arms. The diagnoses have included cervical strain, right cervical radicular symptoms, thoracic strain, right shoulder impingement, status post right shoulder surgery, left shoulder impingement, bilateral forearm flexor tendonitis, wrist tendonitis, carpal tunnel syndrome and secondary depression due to chronic pain. Treatments have included acupuncture, oral medications, Menthoderm topical cream, right shoulder surgery, cervical epidural steroid injections, VQ Stimulator use, physical therapy, and home exercises. In the PR-2 dated 5/1/15, the injured worker complains of persistent neck and upper back pain. She rates her pain level an 8/10. She complains of bilateral shoulder, neck, right upper back, bilateral forearm and wrist pain. She states pain level is 5/10 with medications and an 8/10 without medications. She states her pain decreases with use of medications but she has extreme difficulty in performing her activities of daily living and to do activities with flexing or extending neck. She has mild tenderness to palpation of paracervical muscles with spasm, right greater than left. She has tenderness over the right acromioclavicular and upper deltoid region. She has decreased range of motion in shoulders. She has tenderness of the volar forearm and wrist bilaterally, more on right than the left. She has positive Tinel's and Phalen's signs. She is very tearful and depressed with uncontrollable crying episodes. The treatment plan includes a request to continue to authorize VQ Orthostim and supplies.

IMR ISSUES, DECISIONS AND RATIONALES

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

VQ orthostim for purchase with supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain114-117.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, interferential stimulation is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of transcutaneous stim unit include trial in conjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. It appears the patient has received extensive conservative treatment to include medications and exercise which is documented to control his symptoms. There is no documentation on the short-term or long-term goals of treatment with the interferential unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief, as part of the functional restoration approach to support the request for the Home Orthostim unit purchase as there is no documented failed trial of TENS. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from any transcutaneous stimulation therapy already rendered. The VQ orthostim for purchase with supplies is not medically necessary and appropriate.