

Case Number:	CM15-0199420		
Date Assigned:	10/14/2015	Date of Injury:	09/02/2003
Decision Date:	12/03/2015	UR Denial Date:	10/08/2015
Priority:	Standard	Application Received:	10/09/2015

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: Texas, California
 Certification(s)/Specialty: Family Practice

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 51 year old female, who sustained an industrial injury on September 2, 2003, incurring neck and bilateral shoulder injuries. She was diagnosed with cervical degenerative disc disease with herniations, bilateral shoulder impingement syndrome, and carpal tunnel syndrome. Treatment included physical therapy, anti-inflammatory drugs, topical analgesic creams, neuropathic medications and pain medications. She underwent bilateral carpal tunnel releases, right arthroscopic subacromial decompression and claviclectomy and in April 2014, she had a left subacromial decompression with distal claviclectomy. Currently, the injured worker complained of persistent neck pain, stiffness with throbbing left shoulder pain on 9/1/15. She noted decreased and limited range of motion of both shoulders and limited flexion and extension of the cervical spine and neck. The medication list includes Motrin, gabapentin and Tramadol. The patient's surgical history includes left shoulder surgery on 4/19/13. A recent detailed clinical examination of the gastrointestinal tract was not specified in the records provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Belt kit, back pain relief system, purchase (price/each [REDACTED]): Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, and Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: Belt kit, back pain relief system, purchase (price/each [REDACTED]). This requested kit is meant to provide a form of electrical stimulation. According to the cited guidelines, electrical stimulation (TENS), is "not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Recommendations by types of pain: A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence for the use of TENS as noted below), and for CRPS I (with basically no literature to support use)." According to the cited guidelines, Criteria for the use of TENS is "There is evidence that other appropriate pain modalities have been tried (including medication) and failed. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted." Evidence of neuropathic pain, CRPS I and CRPS II was not specified in the records provided. The patient has received an unspecified number of PT visits for this injury. A detailed response to previous conservative therapy was not specified in the records provided. The previous conservative therapy notes were not specified in the records provided. In addition, a treatment plan including the specific short- and long-term goals of treatment with the TENS unit was not specified in the records provided. The records provided did not specify any recent physical therapy with active PT modalities or a plan to use back pain relief system as an adjunct to a program of evidence-based functional restoration. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The request for Belt kit, back pain relief system, purchase (price/each [REDACTED]) is not medically necessary for this patient.

Solar-care heating system, purchase (only): Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care, and Elbow Complaints 2007.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Solar-care heating system, purchase (only). The requested DME is meant to provide heat therapy, which is a kind of passive physical medicine treatment. Per the CA MTUS chronic pain guidelines cited, "The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially

better clinical outcomes. In a large case, series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability." The rationale for not using simple hot packs versus the use of this DME Solar-care heating system is not specified in the records provided. The response to previous conservative therapy including physical therapy and pharmacotherapy is not specified in the records provided. The request for Solar-care heating system, purchase (only) is not medically necessary for this patient.

X Force stimulator with garments, purchase (price/each [REDACTED]): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: X Force stimulator with garments, purchase (price/each [REDACTED]). The X-Force Stimulator is a proprietary device that utilizes a unique electrical signal to deliver monophasic, peaked impulses directly to the joint. The device is a dual modality unit, offering TEJS and TENS functions that both use electrical stimulation to combat pain found in the joint capsule. According the cited guidelines, electrical stimulation (TENS), is "not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Recommendations by types of pain: A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence for the use of TENS as noted below), and for CRPS I (with basically no literature to support use)." According the cited guidelines, Criteria for the use of TENS is "There is evidence that other appropriate pain modalities have been tried (including medication) and failed. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted." Evidence of neuropathic pain, CRPS I and CRPS II was not specified in the records provided. The patient has received an unspecified number of PT visits for this injury. A detailed response to previous conservative therapy was not specified in the records provided. The previous conservative therapy notes were not specified in the records provided. In addition a treatment plan including the specific short- and long-term goals of treatment with the TENS unit was not specified in the records provided. The records provided did not specify any recent physical therapy with active PT modalities or a plan to use X Force stimulator with garments, purchase (price/each [REDACTED]) as an adjunct to a program of evidence-based functional restoration. Evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The request for X Force stimulator with garments, purchase (price/each [REDACTED]) is not medically necessary for this patient.