

Case Number:	CM15-0025030		
Date Assigned:	02/17/2015	Date of Injury:	04/11/2001
Decision Date:	03/27/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/09/2015

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: New York, Pennsylvania, Washington
 Certification(s)/Specialty: Internal Medicine, Geriatric Medicine

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 63-year-old female, who sustained an industrial injury on April 11, 2001. The diagnoses have included radiculitis, thoracic or lumbosacral, degeneration lumbar disc, lumbar disc displacement, spinal stenosis, lumbar region, lumbosacral spondylosis without myelopathy, insomnia, and constipation. Treatment to date has included oral medications and drug urine screening. Currently, the injured worker complains of back and left leg pain. In a progress note dated January 21, 2015, the treating provider reports examination of gait reveals antalgic gait present tenderness right trapezius muscle to right deltoid and biceps muscles, limited abduction and rotation of the right shoulder due to pain and tenderness over shoulder joint and rotator cuff. On February 4, 2015 Utilization Review non-certified a Quattro 2.5 Russian Muscle Stimulator with six months of supplies, noting, Medical Treatment Utilization Schedule Guidelines was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Quattro 2.5 Russian Muscle Stimulator with 6 months supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 115.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 ?
9792.26 Page(s): 113-117.

Decision rationale: Per the guidelines, an inferential unit 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. In this injured worker, other treatment modalities are not documented to have been trialed and not successful. Additionally, it is not being used as an adjunct to a program of evidence based functional restoration. There is no indication of spasticity, phantom limb pain, post-herpetic neuralgia or multiple sclerosis which the muscle stimulator unit may be appropriate for. The medical necessity for a Russian muscle stimulator unit and supplies is not documented.