

Case Number:	CM14-0124441		
Date Assigned:	09/25/2014	Date of Injury:	03/18/2011
Decision Date:	10/27/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/06/2014

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, has a subspecialty in Interventional Spine, 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 50-year-old female with an injury date of 03/18/2011. According to the 05/14/2014 progress report, the patient complains of having severe pain all over her body, right lower extremity atrophy and weakness, depression, and anxiety. The patient is currently on temporary total disability. She has fatigue, paresthesias, joint stiffness, and hair loss. The patient reports of abdominal bloating and constipation alternating with diarrhea and bloating. In regards to her right leg, she has severe pain which she rates as a 10/10, which comes with weakness, burning sensitivity, and tingling. She also has severe impairment in all activities of daily living and requires assistance for self-care/personal hygiene. Her gait is antalgic and she is unable to walk on toes and heels. The patient ambulates with crutches and presented herself by being tearful, agitated, rocking back and forth in pain, and conjunctivas of her eyes were irritated by crying. She has bilateral frozen shoulders and her right lower extremity is atrophic compared to the left. There is profound sensitivity and weakness in both lower extremities. Lumbar spine x-rays revealed transitional lumbar anatomy and cervical spine x-rays revealed degenerative disk disease. The patient's diagnoses include the following: 1. History of right lower extremity complex regional pain syndrome. 2. Severe fibromyalgia. 3. Sleep disorder. 4. Major depressive disorder. 5. Pain disorder with associated psychological factors and a general medical condition. The utilization review determination being challenged is dated 07/29/2014. Treatment reports were provided from 02/20/2014 - 05/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

PERCUTANEOUS ELECTRICAL NERVE STIMULATOR (NEUROSTIMULATOR), 4 TREATMENTS, OVER THE COURSE OF 30 DAYS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Guidelines pages 118 to 120 state that interferential current stimulation is not recommended.

Decision rationale: According to the 05/14/2014 progress report, the patient complains of having severe pain all over her body. She also has gastrointestinal problems as well as pain in her right leg. The request is for percutaneous electrical nerve stimulator (neurostimulator), for treatments, over the course of 30 days. MTUS Guidelines pages 118 to 120 state that interferential current stimulation is not recommended as an isolated intervention. It is indicated for patient's not tolerating oral medications, post-op pain for example. If indicated, however, MTUS recommends trying the unit for 1 month before a home unit is provided. In this case, there is no indication that the patient has had a 1-month trial of the stimulator. There is no discussion provided as to why the stimulator is necessary. The request is not medically necessary.