

Case Number:	CM14-0058328		
Date Assigned:	07/09/2014	Date of Injury:	11/30/2000
Decision Date:	01/02/2015	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	04/28/2014

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 Orthopedic Surgeon, and is licensed to practice in Texas. 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 injured worker is a 67-year-old male who reported an injury on 11/30/2000. The mechanism of injury was a fall. The injured worker's diagnoses included lumbar radiculopathy, cervical radiculopathy, shoulder pain, carpal tunnel, and bilateral knee pain. The injured worker's past treatments included physical therapy. There were no official diagnostic imaging studies submitted for review. The injured worker's surgical history was noted to include a left shoulder reverse replacement performed on 11/06/2014, a right shoulder arthroscopy with subacromial decompression performed on 04/03/2012, a left knee arthroscopy performed in 2004, and a right carpal tunnel release performed on 06/21/2011. The subjective complaints 08/08/2014 included low back pain. The objective physical exam findings noted decreased range of motion to the lumbar spine and decreased range of motion to the right shoulder. The injured worker's medications were noted to include Soma, Lunesta, Motrin, tramadol, and Lidoderm patch. The treatment plan was for neurostimulation. A request was received for neurostimulator/percutaneous electrical nerve stimulator x4 sessions. The rationale for the request was not documented within the clinical notes. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurostimulator/Percutaneous Electrical Nerve Stimulation Times 4 sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

Decision rationale: The request for neurostimulator/percutaneous electrical nerve stimulation x4 sessions is not medically necessary. The California MTUS Chronic Pain Guidelines state that transcutaneous electrical nerve stimulation is not recommended as a primary treatment modality, but a 1 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. There was a lack of documentation in the clinical notes that the injured worker is participating or going to be participating in an evidence based functional restoration program. In the absence of the information above, the request is not supported by the evidence based guidelines. As such, the request for Neurostimulator/Percutaneous Electrical Nerve Stimulation is not medically necessary.