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| Case Number: | CM15-0070365 | | |
| Date Assigned: | 04/17/2015 | Date of Injury: | 10/08/2010 |
| Decision Date: | 05/21/2015 | UR Denial Date: | 03/23/2015 |
| Priority: | Standard | Application Received: | 04/13/2015 |

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, Tennessee
 Certification(s)/Specialty: Emergency 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 50 year old male, who sustained an industrial injury on 10/08/2010. The mechanism of injury was not noted. The injured worker was diagnosed as having cervical sprain/strain, cervical annular tear with radiculitis and radiculopathy to the right upper extremity, status post right rotator cuff repair in 2012, right shoulder supraspinatus and infraspinatus tendinosis, with subacromial bursitis and adhesive capsulitis, and impingement syndrome of the right shoulder. Treatment to date has included surgical intervention, diagnostics, and medications. Currently (most recent progress report 1/23/2015), the injured worker complains of right shoulder pain with limited range of motion and impingement of the right shoulder. He was very depressed and had anxiety with insomnia. Cervical magnetic resonance imaging from 9/2014 was referenced. Medication use included Naproxen and Neurontin. It was documented that he wanted to go back to work and was to continue home therapy. The recommendation for shoulder continuous passive motion machine was noted, along with medications. An appeal for further payment regarding multi stim rental from 10/29/2014 to 11/28/2014, was noted. Use of the device was not described.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multi-stim unit, one month rental: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 114-115, 118-119, 121.

Decision rationale: Multi-stim unit is a device that provides TENS, interferential, and neuromuscular stimulation. TENS units are 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, including reductions in medication use, for neuropathic pain, phantom limb pain, spasticity, and multiple sclerosis. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. Functional restoration programs (FRPs) are designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. The patient was not participating in a functional restoration program. TENS therapy is not recommended. Interferential current stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. ICS is indicated when pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, there is a history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment, or the pain is unresponsive to conservative measures. In this case there is no documentation that the device is to be used with other recommended treatments. ICS is not indicated. Neuromuscular electrical stimulation (NMES) is not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. The request is not medically necessary.