

Case Number:	CM13-0003717		
Date Assigned:	12/27/2013	Date of Injury:	10/17/2003
Decision Date:	03/31/2014	UR Denial Date:	07/09/2013
Priority:	Standard	Application Received:	07/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine 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 physician 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 72-year-old male with a October 7, 2003 date of injury. At the time of request for authorization for interferential stimulator 4 (orthostim) rental for 2 months and 2 months supplies, there is documentation of subjective (low back pain radiating to the right hip and leg) and objective (antalgic gait, moderate facet tenderness, and diffuse tenderness over the paravertebral musculature) findings, current diagnoses (lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, and bilateral sacroiliac joint arthropathy), and treatment to date (physical therapy and medications).

IMR ISSUES, DECISIONS AND RATIONALES

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

INTERFERENTIAL STIMULATOR 4 (ORTHOSTIM) RENTAL FOR 2 MONTHS AND 2 MONTHS SUPPLIES: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 117-120.

Decision rationale: The OrthoStim unit is a combination of neuromuscular stimulation, interferential current stimulation, Galvanic stimulation, and transcutaneous electrotherapy. The California MTUS Chronic Pain Medical Treatment Guidelines identify that galvanic stimulation is not recommended and considered investigational for all indications; that neuromuscular stimulation is not recommended and is used primarily as part of a rehabilitation program following stroke with no evidence to support its use in chronic pain. Within the medical information available for review, there is documentation of diagnoses of

lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, and bilateral sacroiliac joint arthropathy. However, OrthoStim contains at least one component (Galvanic stimulation) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for an Interferential Stimulator 4 (OrthoStim4) rental for two (2) months and two (2) months of supplies is not medically necessary.

