

Case Number:	CM13-0022972		
Date Assigned:	12/13/2013	Date of Injury:	08/22/2009
Decision Date:	02/19/2014	UR Denial Date:	08/27/2013
Priority:	Standard	Application Received:	09/11/2013

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 Physical Medicine & Rehabilitation and is licensed to practice in California and Maryland. 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 52 year old female who reported an injury on 08/22/2009. The mechanism of injury was folding a cot. Review of the medical record revealed the patient complained of pain of the right forearm, wrist, hand, thumb, low back pain and left knee pain. She stated that the back pain radiated to the left hip and buttocks, left side greater than right, as well as the left lower extremity to the level of the calf. The most recent clinical note is dated 10/17/2013 but it is illegible. This reviewer will refer to the Primary Treating Physician's Supplemental Report. Assessment of the lumbar spine revealed tenderness and spasm over the left sacroiliac joint and bilateral paraspinal musculatures. Also, noted straight leg raise test, sacroiliac test, Faber's test and Gaenslen's test in the left as well as Kemp's test were positive. There was noted restricted range of motion to the lumbar spine. There was noted tenderness over the flexor and extensor tendons as well as the 1st carpometacarpal joint, and a slight tenderness over the right thenar scar area. Examination of the left knee showed tenderness over the medial and lateral joint lines and peripatellar region. There was presence of peripatellar crepitus and limitation in the range of motion of the left knee. Furthermore, decreased sensation to pinprick and light touch were noted along the L4-S1 dermatomes of the left lower extremity. There is mention of an x-ray of lumbar spine and the left knee that was taken on 08/08/2013. The findings were all within normal limits. The patient has previously received acupuncture for the lumbar spine, lower extremities, right thumb, left wrist, left hand, and her left knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home OrthStim IV Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 117, 120-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 119-120.

Decision rationale: Decision for Home OrthStim IV Unit is not medically necessary. Per California Medical Treatment Utilization Schedule (MTUS) guidelines interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of the effectiveness except in conjunction with recommended treatments including, return to work, exercise, medications, and limited evidence of improvement on those recommended treatments alone. The findings from trial usage with interferential current stimulation were either negative or non-interpretable for recommendation. There is no clinical documentation provided in the medical record to suggest that the patient is currently enrolled in any type of treatment modalities in conjunction with the requested service. Per California MTUS Guidelines, the request for the Home OrthStim IV Unit is non-certified.