

Case Number:	CM13-0026647		
Date Assigned:	12/11/2013	Date of Injury:	02/08/2011
Decision Date:	01/29/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	09/19/2013

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. 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 37-year-old male who reported an injury on 02/08/2011. The mechanism of injury was lifting. Initial conservative care was not submitted for review; however, it was noted that the resulting injury was to his lumbar spine. The patient was later noted to have decreased sensation in the L4-5 dermatome on the left side, a positive straight leg raise on the left and restricted range of motion. An Magnetic Resonance Imaging was done on 04/15/2013, and it reported a 5 mm disc protrusion at L4-5; a normal Electromyography was performed to the bilateral lower extremities on 05/07/2013. The patient subsequently received a lumbar epidural steroid injection at L4-5 with a reported 60% decrease in pain. The clinical note dated 08/05/2013 reported that the patient's medications had been helpful. However, there were no visual analogue scale scores to quantify his pain relief. The clinical note also stated that the patient was reporting increased activity levels and a decrease in over-the-counter pain medication use. The patient continued to complain of lower back pain with radicular symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Remover towel mint: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 115-120.

Decision rationale: According to the California Medical Treatment Utilization Schedule (MTUS) Guidelines, the patient does not meet the criteria for the use of an interferential stimulation unit. As such, there is no indication for a remove towel mint. Therefore, the request for a remove towel mint is non-certified.

Conductive spray: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 115-120.

Decision rationale: According to the rationale given in Question #4, the patient does not meet California Medical Treatment Utilization Schedule (MTUS) Guidelines for the use of an interferential stimulation unit. As such, there is no indication for a conductive spray. Therefore, the request for a conductive spray is non-certified.

Electrode: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 115-120.

Decision rationale: As per the rationale given in Question #4, the patient does not meet the California Medical Treatment Utilization Schedule (MTUS) Guidelines for the use of an interferential stimulation unit. As such, there is no indication for electrodes. Therefore, the request for electrodes is non-certified.

Interferential unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 115-120.

Decision rationale: The the California Medical Treatment Utilization Schedule (MTUS) Guidelines do not recommend interferential current stimulation as an isolated intervention. When combined with recommended treatments, including return to work, exercise, and medications, it may be appropriate for certain individuals. Guidelines state that interferential

stimulation can be used if there is objective documentation of pain that is ineffectively controlled due to the diminished effectiveness of medications; pain that is ineffectively controlled due to medication side effects; a history of substance abuse; and a failure to respond to conservative measures. If these criteria are met, guidelines recommend a one month trial to allow the physician to study the benefits. Documentation during the trial period should include an objective increase in functional improvement, less reported pain and evidence of medication reduction. Guidelines also state that a jacket should not be certified until after the one month trial, and only with documentation that the individual cannot apply the stimulation pads independently. The clinical note dated 08/05/2013 reported a decrease in pain, a decrease in the use of medications, and also stated that the patient did not participate in any therapy or home exercise program. As such, the guideline criteria have not been met, and the request for an interferential unit is non-certified.

Leadwire: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 115-120.

Decision rationale: According to the rationale given in Question #4, the patient does not meet the California Medical Treatment Utilization Schedule (MTUS) Guidelines for the use of an interferential stimulation unit. As such, there is no indication for a lead wire. Therefore, the request for a lead wire is non-certified.

Lumbar conductive garment: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 115-120.

Decision rationale: According to the rationale given in Request #4, the patient does not meet the California Medical Treatment Utilization Schedule (MTUS) Guidelines for an interferential stimulation unit. As such, there is no indication for a lumbar conductive garment. Therefore, the request for a lumbar conductive garment is non-certified.

Power pack: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 115-120.

Decision rationale: According to the rationale given in Request #4, the patient does not meet the California Medical Treatment Utilization Schedule (MTUS) Guidelines for an interferential stimulation unit. As such, there is no indication for a power pack. Therefore, the request for a power pack is non-certified.

Tech fee: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation(ICS).

Decision rationale: According to the rationale given in Question #4, the patient does not meet the California Medical Treatment Utilization Schedule (MTUS) Guidelines for an interferential stimulation unit. As such, there is no indication for a tech fee. Therefore, the request for a tech fee is non-certified.