

Case Number:	CM13-0039375		
Date Assigned:	06/06/2014	Date of Injury:	01/20/2012
Decision Date:	07/31/2014	UR Denial Date:	09/26/2013
Priority:	Standard	Application Received:	10/04/2013

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 Emergency 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 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 patient has a reported date of injury on 1/20/2012. Mechanism of injury is described as a fall backwards tripping over a cart. The patient has a diagnosis of lumbar sprain, thoracic/lumbosacral radiculitis and pain in limb. There are reported prior injuries on record. Medical records from primary treating physician and consultants were reviewed. Original prescription is dated 12/7/12, and the requested device was reported use/bought on 1/11/13. The patient has continued complains of neck and back pain, and also reports feeling depressed and anxious. Objective exam is tender with positive straight leg bilaterally and Lasegue bilaterally. The MRI of the lumbar spine shows L4-5 and L5-S1 3mm disc bulge with mild bilateral neural foraminal narrowing. Mild thecal sac nerve root compression at L5-S1. Electrodiagnostic studies were reportedly normal. A medication list was not provided, and the patient was on unknown medication at the time of the original request. There is a report of physical therapy done after the injury but it is not known what else may have been attempted during the time of the original request. Utilization review is for an Interferential Unit purchase along with the electrodes(18 pairs) for use with the unit. The original rationale for request was not found and there is no mention of IF in more recent records. Prior UR on 9/26/13 recommended non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Possible retrospective Interferential Unit purchase DOS: 1/11/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation(ICS)> Page(s): 118-120.

Decision rationale: As per MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS) has very poor evidence as to effectiveness or benefit. MTUS has some basic guidelines before it can be recommended, and the patient does not meet these criteria. There is no proper documentation of ineffective pain control at the time of request, a documentation of a functional restoration plan, or a successful 1 month trial of ICS. As such, the request is not medically necessary.

Electrode purchase (18 pairs) DOS: 01/11/2013: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary request is not medically necessary, none of the associated items are medically necessary.