

<b>Case Number:</b>	CM13-0047765		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	03/01/2013
<b>Decision Date:</b>	06/12/2014	<b>UR Denial Date:</b>	10/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2013

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in New York and Texas. 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 injured worker reported an injury on 03/01/2013 due to an unknown mechanism of injury. The clinical note dated 12/23/2013 noted the injured worker presented with low back pain that radiated to her left hip and left lower extremity. The physical examination of the lumbar spine reported tenderness to palpation over the left L5-S1, left sciatic notch, and left posterior thigh. The injured workers MRI on 09/13/2013 reported a lumbar sprain with left sided radiculopathy, mild to level degenerative disc disease at L4/L5 and L5/S1, mild left L4/L5 lateral recess narrowing with minimal effacement of the transiting left L5 nerve root. The injured worker is recommended for a stim unit 30 day rental. The request for authorization form was not included in the medical documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**COMBO CARE STIM UNIT 30 DAY RENTAL:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-119.

**Decision rationale:** The California MTUS guidelines do not recommend a stim care unit 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. There is a lack of evidence in the documentation provided that would reflect diminished effectiveness of medications, a history of substance abuse, or any postoperative conditions which would limit the injured workers ability to perform exercise programs/physical therapy treatment. It was unclear if the injured worker was unresponsiveness to conservative measures. The requesting physician did not include an adequate and complete assessment of the injured workers objective functional condition which would demonstrate deficits needing to be addressed as well as establish a baseline by which to assess objective functional improvement over the course of therapy. Therefore, the request for combo care stim unit 30 day rental is not medically necessary and appropriate.