

Case Number:	CM13-0048087		
Date Assigned:	12/27/2013	Date of Injury:	07/02/2012
Decision Date:	04/25/2014	UR Denial Date:	10/23/2013
Priority:	Standard	Application Received:	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 Family Medicine and is licensed to practice in Arizona. 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:

Patient reported a date of injury 7/2/2012. Diagnoses include post concussion syndrome, positive tear at left hip labrum, and lumbar spine intervertebral disc degeneration. Subjective complaints are of chronic severe headaches, chronic moderate to severe upper, mid and low back pain, and left hip pain. Physical exam shows decreased range of motion in the cervical spine and back. Patient also has nausea, dizziness, and loss of balance. There is a positive left Kemp's test, positive foraminal compression, and positive left hip fixation. MRI of lumbar spine shows degenerative changes at L4-L5, lumbar CT scan showed broad based central disc protrusion at L5/S1. Electrodiagnostic studies showed bilateral tarsal tunnel syndrome. Prior treatments have included acupuncture, infrared heat, and myofascial release, chiropractic, electrical stimulation, and behavior modification. Medications have included Hydrocodone, Xanax, Naproxen, Omeprazole, Gabapentin, Cyclobenzaprine, and Bupropion.

IMR ISSUES, DECISIONS AND RATIONALES

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

MONTHLY MEDICAL SUPPLIES A4595: 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 requested device is not medically necessary, none of the associated services are medically necessary.

INTERSPEC INTERFERENTIAL (IF) II E 1399: 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 Interferential Therapy Page(s): 118.

Decision rationale: CA MTUS does not recommend interferential therapy as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications. It possibly is appropriate for the following conditions: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. For this patient, none of these criteria were evident in the medical records, and there is no evidence of a one month trial. Therefore, the medical necessity of an interferential device and associated medical supplies is not established.