

Case Number:	CM13-0050457		
Date Assigned:	12/27/2013	Date of Injury:	04/02/2013
Decision Date:	11/10/2014	UR Denial Date:	10/02/2013
Priority:	Standard	Application Received:	10/25/2013

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 New York. 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 is a year-old female who was injured on April 2, 2013. The patient continued to experience pain in cervical spine, lumbar spine, right shoulder, thoracic spine, and left wrist/hand. Physical examination was notable for painful and restricted ranges of motion of the cervical, thoracic, and lumbar spine and muscle spasms of cervical, thoracic, and lumbar spines. Diagnoses included lumbar disc displacement with myelopathy, cervical disc herniation with myelopathy, thoracic disc displacement with myelopathy, bursitis/tendonitis of right shoulder, rotator cuff tear, and tendonitis/bursitis of the left wrist/hand. Treatment included physical therapy and medications. Requests for authorization for interferential muscle stimulator and lumbar support orthosis were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

INTERFERENTIAL MUSCLE STIMULATOR PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS) Page(s): 118-120.

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

Decision rationale: Interferential current stimulation (ICS) is not recommended 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. ICS is indicated when pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, there is a history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment, or the pain is unresponsive to conservative measures. In this case there is no documentation the patient has experienced any of the indications for ICS use. Medical necessity has not been established. The request is not medically necessary and appropriate.

LUMBAR SUPPORT ORTHOSIS PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar supports

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

Decision rationale: There is no evidence for the effectiveness of lumbar supports in preventing back pain in industry. Proper lifting techniques and discussion of general conditioning should be emphasized, although teaching proper lifting mechanics and even eliminating strenuous lifting fails to prevent back injury claims and back discomfort, according to some high-quality studies. There is no medical indication for the lumbar support orthosis. The request is not medically necessary and appropriate.