

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM13-0061632 | | |
| Date Assigned: | 03/03/2014 | Date of Injury: | 06/11/2007 |
| Decision Date: | 09/17/2014 | UR Denial Date: | 11/19/2013 |
| Priority: | Standard | Application Received: | 12/05/2013 |

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 Pain Management 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 injured worker is a 38-year-old male who sustained work-related injuries due to cumulative trauma from June 17, 2011 to February 11, 2013. As per records dated May 24, 2013, the injured worker was requested to undergo six chiropractic treatments as he continued to feel the same. He denied leg pain, but pain in the left knee would go on and off. As per medicals dated November 7, 2013, the injured worker reported that he felt that his low back has slightly improved. However, his primary complaint is that of low back pain. He reported that his low back pain increased if he bends too long. Lumbar spine examination revealed tenderness over the posterior paravertebral musculature, and straight leg raising test was positive in the low back. Range of motion was limited in all planes with pain noted on extension. With regard to his left knee, on and off flare-ups were reported. Left knee examination revealed tenderness over the left patellar region. Range of motion was limited. He was diagnosed with lumbar spine sprain and strain with left lower extremity radiculopathy, 1-2 millimeter disc bulge at L3-L4 and at L4-L5 three-millimeter disc bulge was noted; facet joint osteoarthritis with mild to moderate bilateral neuroforaminal stenosis and two-millimeter L5-S1 disc bulge with facet joint osteoarthritis and moderate to severe bilateral neuroforaminal stenosis as per MRI scan dated March 14, 2010, left sacroiliac joint sprain and strain and bilateral knee patellofemoral arthralgia. This is a review request regarding pain management consultation, Orthostim unit x 2, Electrodes purchase #48, Battery Pack purchase #24, Adhesive Remover Wipes purchase #32, and Shipping purchase #1 for lumbar.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthostim Unit x2 months 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 Transcutaneous electrotherapy Page(s): 114-116.

Decision rationale: Orthostim is composed of various treatment modalities including interferential, neuromuscular, high-volt pulse, and pulsed direct current stimulation. Evidence-based guidelines indicate that the interferential component of Orthostim is not recommended as an isolated intervention and there is no high quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medication and there is limited evidence of improvement on those recommended treatments alone. More so, guidelines indicate a selection criteria if interferential component is to be used which, this includes: 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 significant pain from post-operative conditions which limits the ability to perform exercise programs/physical therapy treatment; or unresponsive to conservative measures. If the said criteria are met, then a one-month trial may be appropriate to study the effects and benefits. In this case, the records of this injured worker indicate that conservative measures including medications, rest, therapy and acupuncture provided none to very minimal pain relief. However, the request made was the two months rental of Orthostim unit which is beyond the 30-day trial recommendation made by evidence-based guidelines. Therefore, the request does not meet the stipulations of evidence-based guidelines and the medical necessity of this request is not established. Moreover, with regard to the high-volt pulsed (Galvanic stimulation) component of this unit, evidence-based guidelines indicate that this component is not recommended and is considered as still under study for all indications. Lastly, Orthostim unit is also composed of a neuromuscular electrical stimulation device which is also not recommended by evidence-based guidelines and there is no evidence to support its use in chronic pain. Based on the presented information, the medical necessity of the requested Orthostim 4 unit is not established therefore not medically necessary.

Electrodes purchase #8: 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 Transcutaneous electrotherapy Page(s): 114-116.

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

Battery Pack purchase #24: 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 Transcutaneous electrotherapy Page(s): 114-116.

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

Adhesive Remover Wipes purchase #32: 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 Transcutaneous electrotherapy Page(s): 114-116.

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