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| Case Number: | CM13-0069841 | | |
| Date Assigned: | 01/03/2014 | Date of Injury: | 02/05/2012 |
| Decision Date: | 04/30/2014 | UR Denial Date: | 12/16/2013 |
| Priority: | Standard | Application Received: | 12/23/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Physical Medicine & Rehabilitation, 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 Physician 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:

This 60 year-old female sustained a right hip injury after being kicked in the abdomen/groin on 2/5/12 while employed by [REDACTED]. Requests under consideration include DME-Interferential unit (SurgiStim) rental with purchase of supplies. Report of 11/12/13 from the provider noted the patient will soon undergo right hip arthroscopy for chondroplasty and iliopsoas release. Request was for SurgiStim4 interferential unit rental for 60 days and cold therapy unit for 60 days. Review of reports has request for H-wave purchase of [REDACTED] in August 2012 that was non-certified. Report of 2/23/12 noted patient with no low back pain and doubtful any lower back injury. The patient has past medical history of insulin dependent Diabetes s/p hysterectomy. Conservative care has included medications, physical therapy and referral to multiple ob/gyn, physiatrist, and general surgeon specialists. DME was noted to decrease pain from 6/10 level to 4/10 with "leg feels lighter." Report of 7/15/12 noted patient with pain level of 8/10; however this pain has decreased 50%, but without any reduction in medications. Diagnosis was Disorder of the Coccyx. The SurgiStim rental above with purchase of supplies was non-certified on 12/16/13 citing guidelines criteria and lack of medical necessity

IMR ISSUES, DECISIONS AND RATIONALES

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

DME-INTERFERENTIAL UNIT (SURGISTIM) RENTAL WITH PURCHASE OF SUPPLIES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 115-118.

Decision rationale: This employee sustained a right hip injury after being kicked in the abdomen/groin on 2/5/12 while employed by [REDACTED]. Requests under consideration include DME-Interferential unit (SurgiStim) rental with purchase of supplies. Report of 11/12/13 from the provider noted the employee will soon undergo right hip arthroscopy for chondroplasty and iliopsoas release. Request was for SurgiStim4 interferential unit rental for 60 days and cold therapy unit for 60 days. Review of reports has request for H-wave purchase of [REDACTED] in August 2012 that was non-certified. Report of 2/23/12 noted the employee with no low back pain and doubtful any lower back injury. The employee has past medical history of insulin dependent Diabetes s/p hysterectomy. Final Determination Letter for IMR Case Number [REDACTED] Conservative care has included medications, physical therapy and referral to multiple ob/gyn, physiatrist, and general surgeon specialists. DME was noted to decrease pain from 6/10 level to 4/10 with "leg feels lighter." Report of 7/15/12 noted employee with pain level of 8/10; however this pain has decreased 50%, but without any reduction in medications. Diagnosis was Disorder of the Coccyx. The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage, increased pain relief or improved work status derived from any transcutaneous electrotherapy to warrant the neuro-stim unit for 60 day use for this February 2012 injury. The employee had previous H-wave trial without any functional benefit according to submitted reports in 2012. The DME-Interferential unit (SurgiStim) rental with purchase of supplies unit for home use is not medically necessary and appropriate