MAXIMUS Federal Services

Case Number:	CM13-0071698		
Date Assigned:	01/08/2014	Date of Injury:	07/09/2013
Decision Date:	06/05/2014	UR Denial Date:	12/09/2013
Priority:	Standard	Application Received:	12/30/2013

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 Sports Medicine and is licensed to practice in 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 is a 46 year old female with a reported date of injury on 07/09/2013. The mechanism of injury was a lifting injury. T he injured worker had complaints of pain to mid Lumbar form L2/L3 down L5/S1 radiating to bilateral posterior iliac crest. The injured worker reported pain at rest was rated 5/10 which increased to 7/10 with activity. When injured worker was examined on 9/30/2013 the injured worker stated her medications were helping. The injured worker reported her pain rated 1/10 and indicated she underwent 12 visits of physical therapy. The injured worker stated the physical therapy helped; however, soreness persists. The injured worker had lumbar spine tenderness to palpation, bending was 70% of normal with pain, extension was 30 degrees with pain, and rotation was 45degrees bilaterally with pain. The injured worker had diagnoses including lumbar sprains/strain, Sciatica, Spasm of muscle. The provider recommended the injured worker continue physical therapy 3x3. The injured worker was provided with Naproxen 500mg, 20 tablets Duraflex comfort Gel 2ouces Tylenol 30 tablets and the estimated length of treatment was 4-6 weeks. The request for authorization was not found in the clinical documentation received.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE INTERFERENTIAL UNIT PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS),.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS), Page(s): 118-120.

Decision rationale: The decision for interferential unit purchase is not medically necessary. The injured worker had complaints of pain to mid lumbar from L2/L3 down L5/S1 radiating to the bilateral posterior iliac crest. With pain at rest rated 5/10 increasing to 7/10 with activity. The Chronic Pain Medical Treatment Guidelines note interferential units are 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. The guidelines note interferential units may possibly be appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: 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 postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). On 09/30/2013 the injured worker reported her medications were helping; she reported pain rated 1/10. The injured worker stated the physical therapy helped; however, soreness persists. The injured worker showed evidence of imporvement with conservative care. It was unclear if the injured worker previously utilized the device and it was documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine. Therefore the decisoin for interferential unit is not medically necessary.