MAXIMUS Federal Services

Case Number:	CM14-0112935		
Date Assigned:	08/04/2014	Date of Injury:	11/18/2013
Decision Date:	09/10/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	07/18/2014

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 a licensed Acupuncturist 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 37-year-old male who reported injury on 11/18/2013. The mechanism of injury was the injured worker was lifting a box weighing more than 150 pounds. Prior treatments additionally included LINT (localized intense neurostimulation therapy). The documentation of 04/16/2014 revealed the injured worker had low back pain along with right lower extremity and knee pain. The documentation indicated the injured worker had received acupuncture, physical therapy, medications and pain management. The surgical history was stated to be none. The injured worker had decreased range of motion in the lumbar spine. The injured worker had 2+ pain on extension and on right lateral bending and right rotation with 1+ pain for the rest of the movements. The injured worker had pain on the spinous processes of L5 and S1. The injured worker had positive facet loading on the right. The straight leg raise was negative. The Patrick/faber test was positive on the right. Deep tendon reflexes were 2+. The diagnoses included lumbar degenerative disc disease with disc bulging at L3-4 of 4 mm, L4-5 of 2 mm to 3 mm and L5-S1 2 mm to 3 mm. Additionally, the diagnoses included lumbar facet arthropathy L4-S1, more on the right, and rule out lumbar radiculopathy. The treatment plan included a lumbar facet block at L4-5, L5-S1 medial branches and if the injured worker had a good response a consideration for radiofrequency facet ablation. The medications included naproxen 500 mg 1 by mouth twice a day, Flexeril 7.5 mg at bedtime and tramadol ER 150 mg daily. Additionally, the request was made for Flurbiprofen/cyclobenzaprine and gabapentin/tramadol compounds, as well as a continuation of chiropractic therapy. There was no DWC form RFA of PR-2 submitted for the requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential (IF) Unit - on month rental, Quantity 1.0, Batteries one month supply Qty:1, Electrodes one month supply Qty 1, Set-up and Delivery Quantity 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The California MTUS Guidelines do not recommend interferential current stimulation as an isolated intervention. The clinical documentation submitted for review failed to provide a DWC Form, RFA or PR2 for the requested service. There was a lack of documentation indicating the injured worker would be utilizing the interferential unit as an adjunct. Given the above, the request for Interferential (IF) Unit - on month rental, Quantity 1.0, Batteries one month supply Qty: 1, Electrodes one month supply Qty 1, Set-up and Delivery Quantity 1 is not medically necessary.

ARS hot/cold Compression Unit purchase, Quantity 1ARS pad/wrap purchase Quantity 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Low Back - Lumbar and Thoracic.

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

Decision rationale: The ACOEM Guidelines indicate that at home local applications of cold are appropriate in the first few days of an acute complaint, thereafter applications of heat and cold. There was no DWC Form, RFA or PR2 submitted for the requested compression unit and wrap. There was a lack of documentation indicating a necessity for a compression unit versus utilization of hot and cold packs. Given the above, the request for ARS hot/cold Compression Unit purchase, Quantity 1 ARS pad/wrap purchase Quantity 1 is not medically necessary.