

Case Number:	CM14-0135907		
Date Assigned:	09/03/2014	Date of Injury:	07/11/2013
Decision Date:	10/03/2014	UR Denial Date:	08/14/2014
Priority:	Standard	Application Received:	08/22/2014

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 Board Certified in Emergency 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 52-year-old female who reported injury on 07/11/2013; while unloading cabbage, she felt a pain in her back. The injured worker had a history of lower back pain. The injured worker had diagnoses of lumbar disc herniation, lumbar post-laminectomy, and chronic pain syndrome. The medications included Hydrocodone/APAP 10/325mg, Lyrica, Ultracet, Concerta, Effexor, and Wellbutrin. Prior treatments included medication, physical therapy, massage therapy, and psychotherapy. The physical examination dated 08/26/2014 of the lumbar spine revealed restricted range of motion, with flexion limited at 50 degrees and extension limited at 15 degrees. The spinous process was tender at the L5 and there was mild tenderness diffusely. The lumbar facet loading was positive on the right. Straight leg raising test was positive bilaterally with sitting at 50 degrees. Muscle strength by examination revealed normal tone, power and nutrition of the muscles. The sensory examination revealed patchy losses to the right lateral leg. The deep tendon reflexes were hyperreflexic. The treatment plan included a bioelectronics radiofrequency device for night use, medication, and follow-up. The Request for Authorization dated 08/26/2014 was submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Recovery Rx: Bio Electronics Radio Frequency Device for use 6-8 hours each night (disp: #40): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain Management January 2014 Vol. 4 No. 1 Pages 37-43, DOI 10.2217/pmt.13.60

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Electromagnetic pulsed therapy, Low back

Decision rationale: The request for Recovery Rx: Bio Electronics Radio Frequency Device for use 6-8 hrs each night (disp: #40) is not medically necessary. The California MTUS and the ACOEM do not address this issue. The Official Disability Guidelines do not recommend it due to the lack of sufficient evidence-based literature to support its use. Studies supporting pulsed electromagnetic field (PEMF) stimulation therapy for occupational back pain are not of high quality. The guidelines advise against this treatment modality. As such, the request is not medically necessary.