

Case Number:	CM14-0184089		
Date Assigned:	11/10/2014	Date of Injury:	07/19/2013
Decision Date:	12/18/2014	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/05/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 patient is a 61 year old female with an injury date of 07/19/13. Based on the 03/21/14 progress report provided by treating physician, the patient complains of low back pain that radiates to the bilateral lower extremities, and inguinal pain. Patient rates her pain 6/10 with and 8/10 without medications. Physical examination to the lumbar spine revealed tenderness to palpation and spasm to the paravertebral, SI (sacroiliac) joint, gluteus and psoas muscles. Range of motion was decreased. Positive bilateral straight leg raises and Kemp's tests. Patient had 12 aquatic therapy and 9 physical therapy visits which provided temporary relief. Patient's medications include Ibuprofen, Remeron, Motrin, Prilosec, and Mirtapizine. Diagnosis 03/21/14- thoracolumbar sprain/strain, bilateral lower extremity radiation, bilateral sacroiliac sprain- facet arthrosis, anterolisthesis L4 on L5, MRI 09/12/13- headache, history head trauma- abdominal pain- sleep difficulty. The utilization review determination being challenged is dated 10/30/14. Treatment reports were provided from 01/10/14 - 08/06/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: OrthoStim 3/Interferential Stimulator with supplies: Upheld

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

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

Decision rationale: The patient presents with low back pain that radiates to the bilateral lower extremities, and inguinal pain. The request is for Retrospective Orthostim 3/ interferential stimulator with supplies. Patient's diagnosis dated 03/21/14 included thoracolumbar sprain/strain, bilateral lower extremity radiation, and bilateral sacroiliac sprain. Patient's medications include Ibuprofen, Remeron, Motrin, Prilosec, and Mirtapizine. Patient is temporarily totally disabled. MTUS (p118-120) states "Interferential Current Stimulation (ICS) Possibly 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.)" Treater has not discussed reason for the request. Per UR letter dated 10/30/14, the request is for purchase. Review of progress reports does not show documentation of patient's history of substance abuse, or operative condition. Per treater report dated 03/21/14, patient rates her pain 6/10 with and 8/10 without medications. Patient had 12 aquatic therapy and 9 physical therapy visits "which provided temporary relief." It appears patient has been responsive to conservative measures. It is not evident that conservative measures have failed. Furthermore, there is no evidence of 30-day home trial demonstrating pain and functional improvement. Since the patient was provided with the unit already, there should have been documentation of pain and functional improvement but this is not found in treater reports. The request is therefore not medically necessary.