

Case Number:	CM14-0038416		
Date Assigned:	06/27/2014	Date of Injury:	08/25/2009
Decision Date:	08/29/2014	UR Denial Date:	03/06/2014
Priority:	Standard	Application Received:	04/01/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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 an 80-year-old female who reported an injury on 08/25/2009. The mechanism of injury was not stated. The current diagnosis is multilevel spondylosis with large disc herniation in the lumbar spine. The current request is for an interferential current stimulation unit with ongoing supplies that was issued on 02/03/2014. However, there was no physician progress report submitted on the requesting date. The latest physician progress report submitted for this review is documented on 11/01/2013. The injured worker presented with complaints of low back pain with numbness and tingling in the bilateral lower extremities. The injured worker had not been previously treated with physical therapy. Physical examination revealed spasm in the lower lumbar spine, painful flexion and rotation, facet joint pain upon palpation, 2+ deep tendon reflexes, decreased range of motion, and mildly positive straight leg raise on the left. Treatment recommendations include an authorization for physical therapy and prescriptions for Cyclobenzaprine, Ultram, and Terocin cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ongoing supplies for existing Interferential Current Stimulation Unit for date of service 2/3/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: The California MTUS Guidelines state interferential current stimulation is not recommended as an isolated intervention. There should be documentation that pain is ineffectively controlled due to the diminished effectiveness of medications or side effects, a history of substance abuse, or significant pain from postoperative conditions. As per the documentation submitted, there is no evidence of a failure to respond to conservative measures. There was no documentation of a successful 1 month trial prior to the unit purchase. There was no physician progress report submitted on the requesting date. Based on the clinical information received, the request for Ongoing supplies for existing Interferential Current Stimulation Unit for date of service 2/3/2014 is not medically necessary and appropriate.