

Case Number:	CM14-0039987		
Date Assigned:	06/27/2014	Date of Injury:	10/28/2011
Decision Date:	08/18/2014	UR Denial Date:	03/05/2014
Priority:	Standard	Application Received:	04/04/2014

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 Pain Medicine and is licensed to practice in Oklahoma, and 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 50-year-old male who reported an injury on 10/28/2011. The mechanism of injury was not provided for review. On 02/03/2014, the injured worker presented with low back pain radiating down the left leg. Treatment included an epidural steroid injection (ESI), medications, and routine urine drug screens. On examination, there was moderate tenderness to palpation over the lumbar paraspinal muscles, left greater than right. There was limited range of motion with sensation noted throughout the left lower extremity. There was a positive straight leg raise to the left. Diagnoses were chronic low back pain, lumbar degenerative disc disease, and lumbar radiculopathy. The provider recommended an OrthoStim unit for 2 months with supplies. The provider's rationale was not provided. The Request for Authorization was dated 02/17/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: Orthostim Unit x 2 months with supplies (Electrodes x8, Batteries x 24, Adhesive remover wipes x32, Shipping and Lead wires x2): 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): 118-119.

Decision rationale: MTUS Guidelines do not recommend a stim care unit as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications. It may be recommended if pain is ineffectively controlled by medications, medication intolerance, history of substance abuse, significant pain from postoperative conditions which limit the ability to perform exercise programs/physical therapy treatment, or unresponsiveness to conservative measures. There is a lack of evidence in the documentation provided that would reflect diminished effectiveness of the medications, a history of substance abuse, or any postoperative conditions which would limit the injured worker's ability to perform exercise programs/physical therapy treatment. Additionally, there is no mention of a 30 day OrthoStim trial to determine the efficacy of the therapy. The provider's request does not indicate whether the OrthoStim unit would be rented or purchased, or the site that it was intended for. As such, the request is not medically necessary.