MAXIMUS Federal Services

Case Number:	CM14-0069914		
Date Assigned:	07/14/2014	Date of Injury:	09/14/2012
Decision Date:	08/13/2014	UR Denial Date:	04/15/2014
Priority:	Standard	Application Received:	05/15/2014

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 Orthopedic Surgery, has a subspecialty in Orthopedic Sports 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 33-year-old male who sustained an injury on 09/14/12 while utilizing a jackhammer. The injured worker developed complaints of pain radiating to the lower extremities. Previous electrodiagnostic studies did note evidence of a left L5-S1 radiculopathy. The injured worker is noted to have had a prior L5-S1 discectomy with associated rhizotomy performed on 03/18/14. Postoperative follow up on 04/03/14 noted that the injured worker continued to have predominant low back pain radiating to the lower extremities, left greater than right, with associated numbness and weakness. The injured worker did describe significant improvement in terms of leg pain, but did report residual low back pain. Medications have included the use of anti-inflammatories and analgesics for pain. The injured worker also was utilizing omeprazole for gastritis. Physical examination noted intact strength in the lower extremities with normal sensation. No reflex changes were identified. The injured worker was referred for further physical therapy and continued on Norco as well as Soma and Colace. Cialis was prescribed for erectile dysfunction that is reported to have been present since the date of injury. The requested two-month rental of an interferential stimulator and Cialis 20 mg #15 with three refills was not granted by utilization review on 04/15/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Two (2) month rental of Interferential stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Pain section.

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

Decision rationale: Based on the clinical information provided, the request for two-month rental of an interferential stimulator, this reviewer would not have recommended this requested DME as medically necessary. According to current evidence based guidelines, interferential current stimulation is not recommended as an isolated intervention. There is limited evidence within the clinical literature establishing the effectiveness of this type of treatment for ongoing chronic low back pain. In this case, there was no clear rationale for the use of interferential current stimulation. It is unclear what benefits were to be expected from the use of this electrical stimulation over a two-month period. It is unclear whether the injured worker was going to be actively enrolled in a rehabilitation program in which this unit would have been utilized as an adjunct. Furthermore, guidelines recommend at most a one-month trial of electrical stimulation therapy for the treatment of myofascial or musculoskeletal pain. Given the excessive nature of the request and the limited documentation to support the use of this durable medical equipment, this reviewer would not have recommended this request as medically necessary. Therefore, the request is not medically necessary.

Cialis 20mg number (#15) with three (3) refills: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Cialis. (2013). In Physicians' desk reference 67th ed.

Decision rationale: In regards to the request for Cialis 20 mg #15 with three refills, this reviewer would not have recommended this request as medically necessary. In review of the clinical documentation submitted, there was no evidence to support a diagnosis of erectile dysfunction. No urology evaluations were noted establishing a diagnosis of erectile dysfunction for which Cialis is an indicated medication. Given the lack of any indications for use of this medication as prescribed on 04/03/14, this reviewer would not have recommended this request as medically necessary. Therefore, the request is not medically necessary.