

Case Number:	CM14-0096301		
Date Assigned:	07/25/2014	Date of Injury:	01/09/2004
Decision Date:	08/29/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/24/2014

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, 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 46 year old female who was injured on 01/09/2004. The mechanism of injury is unknown. The patient underwent a lumbar fluoroscopically guided left L4- medial branch facet rhizotomy; L5-S1 posterior rami facet rhizotomy; L4 medial branch facet rhizotomy; L5-S1 rami facet rhizotomy on 03/21/2014. Progress report dated 04/24/2014 states the patient presented with complaints of medications not helping, specifically Fexmid 7.5 mg. On exam, she had tenderness to palpation of the paravertebral muscles. AROM of the lumbar spine revealed flexion to 45; extension to 12; right bending 15; left bending to 13. She has positive Kemp's test and negative straight leg raise. Diagnoses are lumbosacral sprain/strain. The patient's Fexmid was discontinued. There are no other reports available for review. Prior utilization review dated 06/06/2014 states the request for Interferential Unit (purchase or rental unknown), for Hot/Cold Unit (purchase or rental unknown) is denied as there is a lack of documented evidence to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Unit (purchase or rental unknown): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Interferential Current Stimulation.

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

Decision rationale: As per the guidelines, ICS is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. There are anecdotal reports of the beneficial effects of interferential stimulation in musculoskeletal conditions. The guidelines however suggest that there are no clear evidence-based findings for the usage of interferential stimulation in the management of chronic low back pain. Furthermore, the patient has been recommended for and approved for an injection of the sacroiliac joints. There is no evidence to suggest that interferential stimulation is indicated for sacroiliac joint dysfunction. The medical records fail to indicate a clear medical justification for either of this method of treatment. Based on these guidelines, the diagnosis offered, as well as the clinical documentation stated above, the request is considered as not being medically necessary.

Hot/Cold Unit (purchase or rental unknown): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, cold/heat packs section.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Cold/heat packs.

Decision rationale: The ACOEM recommends no medical evidence to indicate the utility of either a rented or purchased heat/cold. Although these modalities may be beneficial for symptomatic relief, there is no information presented to suggest that such a unit is of any greater benefit than over the counter heat or cold applications. The medical records document no need of this type of treatment modality. Based on these guidelines and criteria as well as the clinical documentation stated above, the request is deemed not to be medically necessary.

Urine Drug Screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 90-91. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Urine Drug Testing (UDT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Urine drug testing (UDT).

Decision rationale: The ODG recommends that urine drug testing be done as part of a compliance program to monitor individuals receiving controlled substances. There is however no evidence in the medical records to document that the patient is taking controlled substances

on a regularly scheduled basis. Therefore, based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.