

Case Number:	CM14-0194235		
Date Assigned:	12/02/2014	Date of Injury:	03/04/1997
Decision Date:	01/14/2015	UR Denial Date:	11/07/2014
Priority:	Standard	Application Received:	11/20/2014

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 Spine Surgery 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 injured worker is a 61-year-old male who reported an injury on 03/04/1997. The mechanism of injury was not provided. The injured worker diagnoses included post laminectomy syndrome, lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome and bilateral sacroiliac joint arthroscopy. The injured worker's past treatments include epidural steroid injections, exercise and medications. The injured worker's diagnostic testing included an MRI of the lumbar spine performed on 10/08/2012, which was noted to reveal multilevel degeneration. There were no relevant surgeries included in the documentation. The most current examination submitted was performed on 02/13/2014. The injured worker reported anxiety with driving; it caused an elevation in his blood pressure. Upon physical examination, the injured worker was noted with a motor strength of 5/5 in the bilateral upper and lower extremities. Sensation was intact to light touch and pain. He was noted with a steady gain and full range of motion in the neck. On 03/17/2014, the injured worker underwent a psychiatric evaluation, he further expressed he continued to have nightmares. He had resumed smoking and rated his customary level of stress as moderate. The injured worker was noted to appear motivated to make changes required soon and be compliant with current treatment plan. The injured worker's current medications were noted to include amlodipine 2.5 mg, Lisinopril/hydrochlorothiazide 20/25 mg, Prozac 40 mg, Xanax 0.5 mg, Protonix 40 mg, clindamycin HDL 300 mg, Bactroban 2% topical ointment, Norco 5/325 mg, Robaxin 500 mg, Wellbutrin XL 150 mg, Zocor 10 mg and aspirin 81 mg. The request was for 1 lumbar spine MRI with gadolinium and 1 interferential stimulator unit with supplies (electrodes, wires, batteries). The rationale for the request was not provided. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

One lumbar spine MRI with gadolinium: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, MRIs

Decision rationale: The request for 1 lumbar spine MRI with gadolinium is not medically necessary. According to the Official Disability Guidelines repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings of significant pathology (tumor, infection, fracture, neural compression and recurrent disc herniation). The injured worker did not complain of low back pain at the time of examination, nor were there any objective neurological deficits documented. The documentation did not provide sufficient evidence of progressive or new neurological deficits upon physical examination. In the absence of documentation with sufficient evidence of a significant change in symptoms and/or findings suggestive of significant new pathology, the request is not supported. As such, the request is not medically necessary.

One interferential stimulator unit (OS4) with supplies- electrodes, wires, batteries: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 118-119, 116.

Decision rationale: The request for 1 interferential stimulator unit (OS4) with supplies (electrodes, wires, batteries) is not medically necessary. According to the California MTUS Guidelines, interferential current stimulation 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. The criteria for the use includes documentation of pain of at least 3 months' duration; evidence that other appropriate pain modalities have been tried (including medication) and failed; a 1 month trial period of the unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. A treatment plan including this specific short and long term goals of treatment with the unit should be submitted. The injured worker did not subjectively complain of low back pain on the date of evaluation. The documentation did not provide sufficient evidence of tried and failed conservative care (including physical therapy, home exercise program and medications). The documentation did not provide evidence of a 1 month trial period with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. In the absence

of documentation with sufficient evidence of significant objective functional deficits, a complete and thorough pain assessment to include a current quantified pain, documented evidence of tried and failed conservative care and documented evidence of a 1 month trial period, the request is not supported. As such, the request is not medically necessary.