

Case Number:	CM14-0208948		
Date Assigned:	12/22/2014	Date of Injury:	06/27/2012
Decision Date:	02/13/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/15/2014

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 Physical Medicine Rehab, has a subspecialty in Interventional Spine 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 44 year old male with an injury date on 06/27/2012. Based on the 11/12/2014 progress report provided by the treating physician, the diagnoses are:1. Lumbar disc disease2. Lumbar radiculopathy3. Lumbar facet syndrome According to this report, the patient complains of "pain in the low back, which he rates on a pain scale at 4-5/10 and depending to physical activity can shoot up to 8/10. The pain is described as achy, sharp, burning and throbbing, traveling to the bilateral into the feet with numbness and tingling sensation." Physical exam reveals diffuse tenderness over the lumbar paravertebral musculature and L4-S1 spinous processes. Heel-toe walk was difficult to perform secondary to pain. Kemp's test, Straight Leg Raise test, Farfan test, and Patellar Compression are positive. Decreased sensation is noted at the bilateral L4, L5, and S1 dermatomes. Motor strength of the bilateral big toe extension and knee extension is 4/5. Treatment to date includes left knee surgery in 2013. The treatment plan is to request for "1-2 month(s) rental" of the Interferential stimulator unit, "purchase of Interferential stimulator unit and continued necessary supplies for long term use," bilateral L4-L5 and L5-S1 transforaminal epidural steroid injections, L4 -S1 medial branch blocks, continue with current medications, and undergo urine drug testing. There were no other significant findings noted on this report. The utilization review denied the request Interferential stimulator unit 30 day trial for home use with supplies on 12/03/2014 based on the MTUS guidelines. The requesting physician provided treatment reports from 02/22/2014 to 11/18/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Stimulator, 30 Day Trial for Home Use: Upheld

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

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

Decision rationale: According to the 11/12/2014 report, this patient presents with 4-5/10 low back pain. The current request is for Interferential stimulator times 30 day trial for home use. The MTUS Guidelines page 118 to 120 states that interferential current stimulation is not recommended as an isolated intervention. MTUS also recommends trying the unit for one-month before a home unit is provided if indicated. Indications are pain ineffectively controlled with medication; history of substance abuse; post-operative use; unresponsive to conservative measures. "If those criteria are met, then a one-month trial may be appropriate." In this case, the treating physician documents that the "patient has failed conservative treatment (including drug therapy, activity modifications, and/or physical therapy). However, there is no documentation of "history of substance abuse or significant pain from postoperative conditions required by the MTUS. Therefore, the current request is not medically necessary.

Electrodes packs QTY - 4 packs: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 8.

Decision rationale: According to the 11/12/2014 report, this patient presents with 4-5/10 low back pain. The current request is for Electrodes packs QTY: 4 packs. The Utilization Review denial letter states "Without approval of the unit, the requested electrodes packs, power packs, adhesive remover towel mint, lead wire, tech fit with instruction are not medically necessary." MTUS guidelines page 8 states that the provider must monitor the patient and provide appropriate treatment recommendations. In this case, the requested Electrodes packs are not recommended as the Interferential stimulator Unit is not medically necessary. Therefore, the current request is not medically necessary.

Power packs QTY - 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 8.

Decision rationale: According to the 11/12/2014 report, this patient presents with 4-5/10 low back pain. The current request is for Power packs QTY: 12. The Utilization Review denial letter states "Without approval of the unit, the requested electrodes packs, power packs, adhesive remover towel mint, lead wire, tech fit with instruction are not medically necessary." MTUS guidelines page 8 states that the provider must monitor the patient and provide appropriate treatment recommendations. In this case, the requested power packs are not recommended as the Interferential stimulator Unit is not medically necessary. Therefore, the current request is not medically necessary.

Adhesive remover towel mint QTY - 16: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 8.

Decision rationale: According to the 11/12/2014 report, this patient presents with 4-5/10 low back pain. The current request is for Adhesive remover tower mint QTY: 16. The Utilization Review denial letter states "Without approval of the unit, the requested electrodes packs, power packs, adhesive remover towel mint, lead wire, tech fit with instruction are not medically necessary." MTUS guidelines page 8 states that the provider must monitor the patient and provide appropriate treatment recommendations. In this case, the requested Adhesive remover tower is not recommended as the Interferential stimulator Unit is not medically necessary. Therefore, the current request is not medically necessary.

Leadwire QTY - 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 8.

Decision rationale: According to the 11/12/2014 report, this patient presents with 4-5/10 low back pain. The current request is for Leadwire QTY: 1. The Utilization Review denial letter states "Without approval of the unit, the requested electrodes packs, power packs, adhesive remover towel mint, lead wire, tech fit with instruction are not medically necessary." MTUS guidelines page 8 states that the provider must monitor the patient and provide appropriate treatment recommendations. In this case, the requested Leadwire is not recommended as the Interferential stimulator Unit is not medically necessary. Therefore, the current request is not medically necessary.

Tech fit with instruction - 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 8.

Decision rationale: According to the 11/12/2014 report, this patient presents with 4-5/10 low back pain. The current request is for Tech fit with instruction - 1. The Utilization Review denial letter states "Without approval of the unit, the requested electrodes packs, power packs, adhesive remover towel mint, lead wire, tech fit with instruction are not medically necessary." MTUS guidelines page 8 states that the provider must monitor the patient and provide appropriate treatment recommendations. In this case, the requested Tech fit with instruction is not recommended as the Interferential stimulator Unit is not medically necessary. Therefore, the current request is not medically necessary.