

Case Number:	CM15-0145360		
Date Assigned:	08/06/2015	Date of Injury:	07/01/2013
Decision Date:	09/02/2015	UR Denial Date:	07/06/2015
Priority:	Standard	Application Received:	07/27/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 38-year-old male who sustained an industrial injury on 7-1-13. He had complaints of his left side including neck, shoulder, back and leg. Treatments include: medication, physical therapy, chiropractic, injections, nerve block and shoulder surgery. Progress report dated 6-26-15 reports continued complaints of neck and low back pain with radiation into the right lower extremity and foot drop. The pain is described as aching. Left shoulder is status post decompression. The pain in his right leg is rated 9 out of 10 without medication. His activity is very limited, which impairs weight loss. He needs to lose weight before he can have lumbar surgery for the right lower extremity pain and foot drop. Diagnoses include: radiculopathy lower spine, peripheral vertigo, mood disorder, insomnia, sprain and strain shoulder and upper arm, cervical spondylosis and headache. Plan of care includes: continue 25 mcg-hour patch every 72 hours with oxycodone 4 times per day. Pain agreement signed.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF Unit DOS 6/17/15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, pages 115-118, Interferential Current Stimulation (ICS).

Decision rationale: The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage, increased pain relief or improved functional status derived from any transcutaneous electrotherapy to warrant a rental/ purchase of an interferential unit for home use for this chronic 2013 injury. Additionally, IF unit may be used in conjunction to a functional restoration process with improved work status and exercises not demonstrated here. The IF Unit DOS 6/17/15 is not medically necessary and appropriate.