

Case Number:	CM15-0168358		
Date Assigned:	09/09/2015	Date of Injury:	09/13/2012
Decision Date:	10/14/2015	UR Denial Date:	07/27/2015
Priority:	Standard	Application Received:	08/26/2015

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: Pennsylvania, Ohio, 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 41 year old male, who sustained an industrial injury on 9-13-12. Initial complaints were not reviewed. The injured worker was diagnosed as having pain in limb; lumbosacral radiculopathy; hip sprain-strain; generalized pain; degenerative bulging disc L5-S1 with low back pain and right lower limb radiculitis; internal derangement right hip with pain in right hip; right inguinal hernia; trochanteric bursitis right hip. Treatment to date has included physical therapy; chiropractic therapy; aquatic therapy; right sacroiliac joint injections; [REDACTED] (no report-no date); medications. Diagnostics studies included EMG-NCV study of the lower extremities - normal (5-14-14); MRI right hip-unremarkable (5-12-15). Currently, the PR-2 notes dated 7-6-15 indicated the injured worker complains of lower back pain and right-sided hip pain with radiating pain downright lower extremity with numbness, tingling and weakness. He also describes pain in the right inguinal region. He reports he has difficulty with prolonged sitting, standing, walking, squatting, kneeling and stooping. The provider mentions a MRI of the right hip which findings were unremarkable on 5-12-15. The provider documents he is requesting an interferential unit to be provided for the injured worker to use at home on a daily basis to help reduce muscular tension, reduce pain, and increase musculoskeletal function, which will facilitate activities of daily living. He is also requesting the [REDACTED] from which he has benefited. He is asking for an additional 10 weeks to help reduce the stress over the lumbar spine and the right lower extremity to avoid further aggravation of his "industrial injury". The medical documentation submitted does not reveal a start date of the initial [REDACTED] or of benefit to date the injured worker has resulted from

the initial program. A Request for Authorization is dated 8-26-15. The Utilization Review letter is dated 7-27-15 and non-certification for the [REDACTED], quantity: 10 weeks and Interferential unit, quantity one. The provider is requesting authorization of [REDACTED], quantity: 10 weeks and Interferential unit, quantity one.

IMR ISSUES, DECISIONS AND RATIONALES

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

[REDACTED], **quantity: 10 weeks: 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 ACOEM Chapter 7 Consultation Page 127.

Decision rationale: ACOEM recommends consultation with another professional if this may be beneficial in managing a patient's treatment. In this case it is unclear if the requested treatment program is medically supervised; without medical supervision, there is no mechanism to apply a guideline to this request as a form of medical treatment. Therefore this request is not medically necessary.

Interferential unit, quantity one: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: MTUS recommends interferential stimulation as an option in specific clinical situations after first-line treatment has failed. Examples of situations where MTUS supports interferential stimulation include where pain is ineffectively controlled due to diminished effectiveness of medication or medication side effects or history of substance abuse. The records do not document such a rationale or alternate rationale as to why interferential stimulation would be indicated rather than first-line treatment. Therefore this request is not medically necessary.