

Case Number:	CM15-0183848		
Date Assigned:	09/24/2015	Date of Injury:	08/05/2013
Decision Date:	12/02/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/18/2015

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: Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 54 year old female sustained an industrial injury on 8-5-13. Documentation indicated that the injured worker was receiving treatment for lumbar sprain and strain and left knee patellofemoral arthralgia. Previous treatment included physical therapy, interferential unit and medications. In the most recent relevant documentation submitted for review, a PR-2 dated 6/2/15, the injured worker complained of low back pain that interfere with sitting, walking, bending and lifting. Physical exam was remarkable for left knee with tenderness to palpation to the peri-patellar and medial and lateral joint lines with range of motion 0 to 138 degrees and lumbar spine with tenderness to palpation to the paraspinal musculature, lumbar facets and left sacroiliac joint with positive Kemp's test and left Fabere's but negative straight leg raise. The treatment plan included a pain management consultation; follow up with psychiatry and continuing home exercise. The medications listed are Anaprox and Prilosec. On 7-7-15, a request for authorization was submitted for purchase of an Orthostim 4, elect VQ 2in and N-S, battery VQ pack AA and electro shipping. On 8-18-15, Utilization Review non-certified a request for retrospective purchase of Orthostim 4, elect VQ 2in and N-S, battery VQ pck AA and electro shipping (DOS 7-7-15).

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective purchase of Orthostim 4 (DOS 07/07/15): 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): Electrical stimulators (E-stim). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Stimulators.

Decision rationale: The CA MTUS did not address the use of Stimulation units except in the post operative period following musculoskeletal surgery. The ODG guidelines noted that Ortho Stimulation treatment may be beneficial in specific musculoskeletal conditions including abnormal bone healing conditions. The records did not show the presence of recent surgery or musculoskeletal abnormality that met the guidelines criteria. The records did not show that conservative treatment with medications, exercise, behavioral modification and PT had been optimized. The patient was noted to be utilizing Interferential (IF) Unit treatment. There is no documentation of efficacy of the IF unit or if the Ortho Stimulator unit will be utilized in conjunction with the IF unit. The criteria for Retrospective purchase of Orthostim 4 DOS 07/07/2015 was not met, therefore is not medically necessary.

Retrospective purchase of elect VQ 2in and N-S (DOS 07/07/15): 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): Electrical stimulators (E-stim). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Stimulators.

Decision rationale: The CA MTUS did not address the use of Stimulation units except in the post operative period following musculoskeletal surgery. The ODG guidelines noted that Ortho Stimulation treatment may be beneficial in specific musculoskeletal conditions including abnormal bone healing conditions. The records did not show the presence of recent surgery or musculoskeletal abnormality that met the guidelines criteria. The records did not show that conservative treatment with medications, exercise, behavioral modification and PT had been optimized. The patient was noted to be utilizing Interferential (IF) Unit treatment. There is no documentation of efficacy of the IF unit or if the Ortho Stimulator unit will be utilized in conjunction with the IF unit. The criteria for Retrospective purchase of Orthostim 4 DOS 07/07/2015 was not met therefore the Retrospective purchase of elect VQ 2in and N-S DOS 07/07/2015 was not met, therefore is not medically necessary.

Retrospective purchase of battery VQ pck AA (DOS 07/07/15): 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): Electrical stimulators (E-stim). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Stimulators.

Decision rationale: The CA MTUS did not address the use of Stimulation units except in the post operative period following musculoskeletal surgery. The ODG guidelines noted that Ortho Stimulation treatment may be beneficial in specific musculoskeletal conditions including abnormal bone healing conditions. The records did not show the presence of recent surgery or musculoskeletal abnormality that met the guidelines criteria. The records did not show that conservative treatment with medications, exercise, behavioral modification and PT had been optimized. The patient was noted to be utilizing Interferential (IF) Unit treatment. There is no documentation of efficacy of the IF unit or if the Ortho Stimulator unit will be utilized in conjunction with the IF unit. The criteria for Retrospective purchase of Orthostim 4 DOS 07/07/2015 was not met therefore the criteria for Retrospective purchase of battery VQ pck AA DOS 07/07/2015 was not met, therefore is not medically necessary.

Retrospective purchase of electro shipping (DOS 07/07/15): 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): Electrical stimulators (E-stim). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Stimulators.

Decision rationale: The CA MTUS did not address the use of Stimulation units except in the post operative period following musculoskeletal surgery. The ODG guidelines noted that Ortho Stimulation treatment may be beneficial in specific musculoskeletal conditions including abnormal bone healing conditions. The records did not show the presence of recent surgery or musculoskeletal abnormality that met the guidelines criteria. The records did not show that conservative treatment with medications, exercise, behavioral modification and PT had been optimized. The patient was noted to be utilizing Interferential (IF) Unit treatment. There is no documentation of efficacy of the IF unit or if the Ortho Stimulator unit will be utilized in conjunction with the IF unit. The criteria for Retrospective purchase of Orthostim 4 DOS 07/07/2015 was not met therefore the criteria for Retrospective purchase of electro shipping DOS 07/07/2015 was not met, therefore is not medically necessary.