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| Case Number: | CM15-0198549 | | |
| Date Assigned: | 10/13/2015 | Date of Injury: | 10/17/2013 |
| Decision Date: | 11/25/2015 | UR Denial Date: | 09/22/2015 |
| Priority: | Standard | Application Received: | 10/09/2015 |

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:

This injured worker is a 37 year old female who reported an industrial injury on 10-17-2013. The history noted a second work-related motor vehicle accident on 10-3-2013. Her diagnoses, and or impressions, were noted to include: left knee injury, status-post left knee arthroscopy (9-18-14), with significant post-operative residuals and patella-femoral arthralgia; and cervical musculoligamentous sprain-strain; and osteoarthritis of the knee. Recent magnetic imaging studies of the left knee were done in 4-9-2015, and described to be within normal limits. Her treatments were noted to include: 3 left knee Euflexxa injections (Jan., 2015); medication management; and modified work duties. The progress notes of 7-14-2015 were hand written and difficult to decipher, but were noted to report: increased low back pain with lifting, movements and activities, and decreased with her medications. The objective findings were noted to include: bilateral sacroiliac joint pain with muscle spasms and decreased range-of-motion; positive Gaenslen's, Yeoman's and bilateral sacroiliac stress tests; and positive straight leg raise tests. The physician's request for treatment was noted to include. No Request for Authorization was noted for Fexmid or an interferential (IF) unit. The Utilization Review of 9-22-2015 non-certified the request for: Fexmid 7.5 mg, #60; and modified the request for a home IF stimulator unit, to a 30 day trial of an IF unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home interferential stimulator unit: 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: The patient presents with low back pain. The request is for HOME INTERFERENTIAL STIMULATOR UNIT. Physical examination to the lumbar spine on 07/14/15 revealed tenderness to palpation over the paraspinals with spasm. Range of motion was noted to be decreased. Per 06/01/15 progress report, patient's diagnosis include status post left knee arthroscopy performed on September 18/2014, with significant post-operative residuals and patellofemoral arthralgia, lumbosacral musculoligamentous sprain/strain with left sacroiliac joint sprain, and cervical musculoligamentous sprain/strain. Patient's medication, per 04/28/15 progress report includes Norco. Patient's work status is modified duties. For Interferential Current Stimulation (ICS), MTUS guidelines, pages 118 - 120, state that 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. These devices are recommended in cases where: (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or (4) Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (5) Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). Treater has not discussed this request and no RFA was available either. In this case, there is no evidence that medications and conservative care are ineffective or that the patient has a history of substance abuse. The treater does not document side effects due to medication. An IF unit would not be indicated without first documenting successful outcome of a one month trial. Furthermore, the treater has not indicated whether the unit is for purchase or rental. Given the lack of any discussion regarding the request, the indication for the use of this unit cannot be determined. The request IS NOT medically necessary.