

Case Number:	CM15-0208196		
Date Assigned:	10/27/2015	Date of Injury:	08/05/2015
Decision Date:	12/30/2015	UR Denial Date:	10/13/2015
Priority:	Standard	Application Received:	10/22/2015

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: Georgia

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:

The injured worker is a 73 year old female, who sustained an industrial-work injury on 8-5-15. A review of the medical records indicates that the injured worker is undergoing treatment for possible lumbar strain and sprain, possible bilateral lumbar facet pain and possible lumbar discogenic pain. Medical records dated 9-28-15 indicate that the injured worker complains of axial type low back pain. The pain is rated 2-5 out of 10 on the pain scale which has been unchanged from previous visits. Per the treating physician report dated 9-28-15 the injured worker has not returned to work and work status is temporary total disability until 10-31-15. The physical exam reveals that the back has bilateral facet lumbar tenderness, positive lumbar facet loading, and lumbar spine movements are painful. Treatment to date has included pain medication, 4 sessions of chiropractic physical therapy with improvement, home exercise program (HEP) and stretching exercises, diagnostics, X-ray of the lumbar spine and other modalities. The lumbar x-rays were not noted. The request for authorization date was 9-28-15 and requested services included 2 Batteries, 2 Packs of Electrodes, Set Up and Delivery, and 1 Month Rental of Interferential Unit (IF) Unit. The original Utilization review dated 10-13-15 non-certified the request for 2 Batteries, 2 Packs of Electrodes, Set Up and Delivery, and 1 Month Rental of IF Unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Month Rental of IF Unit: Upheld

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

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

Decision rationale: 1 Month Rental of IF Unit is not medically necessary. Per MTUS, Inferential Current is 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. As it relates to this case inferential current was recommended with home exercise therapy for chronic pain however there was no mention of plan to return work. Per MTUS and the previously cited medical literature inferential current is not medically necessary as solo therapy or without plans of return to work.

Associated services: 2 Batteries: Upheld

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

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated services: 2 Packs of Electrodes: Upheld

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

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated services: Set Up and Delivery: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.