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| Case Number: | CM15-0025399 | | |
| Date Assigned: | 02/17/2015 | Date of Injury: | 02/04/2002 |
| Decision Date: | 03/26/2015 | UR Denial Date: | 01/16/2015 |
| Priority: | Standard | Application Received: | 02/10/2015 |

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 50 year old male sustained an industrial injury on 2/4/02, with subsequent ongoing low back pain. Treatment included chiropractic therapy, physical therapy and medications. In a PR-2 dated 9/2/14, the physician noted that an updated magnetic resonance imaging lumbar spine showed a new disc bulge at L3-4 with ongoing disc bulges at L4-5 and L5-S1. The injured worker complained of increased low back pain with radiation to bilateral lower extremity. The injured worker reported difficulty exercising due to pain and weight gain. Physical exam was remarkable for decreased range of motion of the lumbar spine with paravertebral tenderness to palpation and spasms and positive straight leg raise. The treatment plan included a weight loss program and a gym membership. An interferential unit and heating pad were dispensed for pain. On 1/16/15, Utilization Review noncertified a request for Interferential Stimulation Unit citing CA MTUS Chronic Pain Medical Treatment Guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Stimulation Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Current Stimulation (ICS), p118-120 Page(s): 118-120.

Decision rationale: The claimant is more than 10 years status post work-related injury and continues to be treated for chronic low back pain. Criteria for use of an interferential stimulation unit include evidence of increased functional improvement, less reported pain and evidence of medication reduction during a one month trial. In this case, the claimant has not undergone a trial of interferential stimulation and therefore providing a home interferential unit was not medically necessary.