

<b>Case Number:</b>	CM15-0028649		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	05/08/2006
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	01/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/17/2015

### 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 50-year-old female who sustained a work related injury May 8, 2006. Past medical history includes hypertension. According to a primary treating physician's progress notes dated January 7, 2015, the injured worker presented with complaints of lower back pain radiating to the bilateral lower extremities with numbness and tingling. The continued handwritten notes are not legible to this reviewer. Treatment plan included requests for medication, interferential unit with supplies, given walker and schedule with pain management physician for re-evaluation. According to an interventional pain management follow-up re-evaluation report, dated January 21, 2014, an MRI done on December 23, 2014(report not present in medical record), showed at L5-S1 a 3mm left foraminal disc protrusion resulting in abutment of the exiting L5 nerve root with narrowing of the left neural foramen; at L4-L5 there was a posterior annular tear and 3mm left foraminal disc protrusion with abutment of the exiting left L4 nerve root and mild narrowing of the left neural foramen. Diagnoses documented as lumbar sacral discopathy, radiculopathy and facet syndrome. According to utilization review dated January 20, 2015, the request for Interferential Unit (1) month rental is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines. The request for Electrode Packs (4) is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines. The request for Power Pack #12 was non-certified, citing Chronic Pain Medical Treatment guidelines. The request for Adhesive Remover Towel Mitt #16 is non-certified, citing ODG-Durable Medical Equipment. The request for Lead Wire #1 for Lumbar/Neck/ Right shoulder is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines. The request for a Dispensed Wheeled Walker for

ambulation is non-certified, citing ODG-Durable Medical Equipment. The request for Home Care Assistance (3) days a week, (4) hours a day for 96) weeks (72 hours) is non-certified, citing ODG-Home Health Services.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Interferential Unit, 1 Month Rental: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

**Decision rationale:** According to MTUS, Interferential Current Stimulation (ICS) 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. There are no standardized protocols for the use of interferential therapy. A one-month trial may be appropriate in cases where pain is ineffectively controlled due to diminished effectiveness of medication due to side effects, there is a history of substance abuse, there is significant post-operative pain, or if the patient is unresponsive to conservative measures. There is no indication for use of this treatment. The documentation indicates that there has been limited conservative care to date. The documentation failed to reveal evidence of diminished effectiveness of medications or side effects. Medical necessity for the requested interferential unit has not been established. The requested treatment is not medically necessary.

#### **Electrodes Packs, #4: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

**Decision rationale:** As the IF unit was not certified, medical necessity for the requested electrodes is not established. The requested electrodes are not medically necessary.

#### **Power Pack, #12: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

**Decision rationale:** As the IF unit was not certified, medical necessity for the requested power pack has not been established. The requested power pack is not medically necessary.

**Adhesive Remover Towel Mint, #16:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

**Decision rationale:** As the IF unit was not certified, medical necessity for the requested Adhesive Remover Towel Mint, #16 has not been established. The requested Adhesive Remover Towel Mint #16 is not medically necessary.

**Lead Wire, #1 for Lumbar/Neck/Right Shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

**Decision rationale:** As the IF unit was not certified, medical necessity for the requested Lead Wire, # 1 for Lumbar/Neck/Right Shoulder has not been established. The requested Lead Wire, # 1 for Lumbar/Neck/Right Shoulder is not medically necessary.

**Wheel Walker for Ambulation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Durable Medical Equipment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Durable Medical Equipment.

**Decision rationale:** According to ODG, a walker is recommended if the patient requires this for ambulation. There is no specific documentation indicating that the patient requires a wheel-walker to assist with ambulation. There is no specific documentation indicating the patient requires a walker. In addition, the medical records provided were illegible. Medical necessity for the requested item has not been established. The requested wheel-walker is not medically necessary.

**Home Care Assistance 3 days a week, 4 hours a day, for 6 weeks (72 hours):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Home Health Services.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare Coverage Criteria/Home Health Care Services.

**Decision rationale:** According to CA MTUS guidelines, home health services are recommended treatment for patients who are homebound on a part time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services such as shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. The treating provider has not indicated any specific skilled care needs the patient will require. Medical necessity has not been established. The requested service is not medically necessary.