

Case Number:	CM15-0219629		
Date Assigned:	11/12/2015	Date of Injury:	01/29/2001
Decision Date:	12/30/2015	UR Denial Date:	10/30/2015
Priority:	Standard	Application Received:	11/09/2015

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, Hawaii

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:

The injured worker is a 59 year old female, who sustained an industrial injury on 1-29-01. The injured worker is diagnosed with thoracic-lumbar intervertebral disc without myelopathy, lumbar sprains and strains, neck. Her work status is modified duty. Notes dated 9-21-15 and 10-19-15 reveals the injured worker presented with complaints of low back pain that radiates pain to the left leg, right buttock and bilateral feet accompanied with numbness and tingling and decreased range of motion. Her pain is described as dull, sharp, numbness and aching and is rated at 7-8 out of 10. Physical examinations dated 8-3-15, 9-21-15 and 10-19-15 revealed tenderness to palpation at the bilateral lumbar paraspinal musculature and. the straight leg raise elicits left lower extremity numbness and tingling. There is decreased range of motion, decreased sensory bilateral L4, L5 and S1 bilaterally (left greater than right). Of note, some of the progress note dated 10-19-15 is difficult to decipher. Treatment to date has included an interferential home unit, which provides her with relief to continue to work per note dated 10-19-15. Medications cause stomach upset; therefore, the injured worker tries to avoid oral medications. She does take Tylenol #3, Lidocaine patch, Gabapentin and Nortriptyline, which allows for decreased symptoms, allows for up to 4 hours of sleep and reduces her pain from 8 out of 10 to 5-6 out of 10. The injured worker has had lumbar spine surgical intervention x3. Diagnostic studies include lumbar spine x-rays and CT scan and electrodiagnostic study. A request for authorization dated 10-19-15 for interferential home unit replacement is non-certified, per Utilization Review letter dated 10-30-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Replace Interferential Home Unit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation CA MTUS, Interferential current stimulation.

Decision rationale: The records indicate the patient has chronic complaints of low back pain with radiation into the lower extremity, dysesthesia, numbness and tingling. The current request for consideration is replace interferential home unit. In the progress report dated 10/19/15, the attending physician states that the patient's home interferential unit has stopped working and she requests a new one. The CA MTUS has this to say regarding interferential current stimulation. 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 CA MTUS requires documentation of the effectiveness of the interferential stimulation unit as it relates to decreasing pain levels and decreasing medication use. In this case, there is no documentation that the use of interferential for home use has decreased the patient's medication use or decreased the patients overall pain levels. Furthermore, there is no mention that the interferential is being used in conjunction with an exercise program or as part of a functional restoration program. The available records do not establish medical necessity. The request is not medically necessary.