

Case Number:	CM15-0045326		
Date Assigned:	03/17/2015	Date of Injury:	12/17/2014
Decision Date:	11/20/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	03/10/2015

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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 28 year old female who sustained an industrial injury on 12-17-2014. A review of the medical records indicated that the injured worker is undergoing treatment for coccydynia, sacralgia and low back pain. According to the treating physician's progress report on 02-18-2015, the injured worker continues to experience left lower back pain and when the area is pressed shoots down to the left lower extremity rated at 7 out of 10 on the pain scale. Examination demonstrated an antalgic gait with motor strength noted at 5 out of 5 with poor effort in the left lower extremity. Sensation and deep tendon reflexes were intact bilaterally. Straight leg raise recreates back pain on the left. The sacroiliac region was less tender than the previous examination. Range of motion was limited due to pain. Lumbar spine magnetic resonance imaging (MRI) performed on 02-11-2015 was reported as normal in the official reports included in the review. Computed Tomography (CT) of the sacrum and coccyx was reported as normal within the review dated 02-18-2015. Prior treatments have included diagnostic testing, chiropractic therapy and medications. Current medications were listed as Oxycodone and Valium. Treatment plan consists of diagnostic and therapeutic trigger point injection; continuing medication regimen and the current request for an Interferential Stimulator (IF) unit for 3 months home use, garment purchase and lumbosacral orthosis. On 02-27-2015 the Utilization Review determined the request for an Interferential Stimulator unit for 3 months home use, garment purchase and lumbosacral orthosis was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential unit x 3 months home use: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009.

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

Decision rationale: The device being requested is a combination unit providing neuromuscular electrical stimulation (NMES) and interferential unit. Per MTUS guidelines, the NMES is not recommended for the treatment of chronic pain. The MTUS Guidelines do not recommend an interferential stimulator as an isolated treatment; however, it may be useful for a subset of individuals that have not had success with pain medications. The evidence that an interferential stimulator is effective is not well supported in the literature, and studies that show benefit from use of the interferential stimulator are not well designed to clearly demonstrate cause and effect. The guidelines support the use of an interferential stimulator for a one-month trial to determine if this treatment modality leads to increased functional improvement, less reported pain and medication reduction. The request is not for a one-month trial however, and the unit and NMES is not recommended by the guidelines. Therefore, the request for Interferential unit x 3 months home use is not medically necessary.

Garment purchase: 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, Electrical stimulators (E-stim).

Decision rationale: The device being requested is a combination unit providing neuromuscular electrical stimulation (NMES) and interferential unit. Per MTUS guidelines, the NMES is not recommended for the treatment of chronic pain. The MTUS Guidelines do not recommend an interferential stimulator as an isolated treatment; however, it may be useful for a subset of individuals that have not had success with pain medications. The evidence that an interferential stimulator is effective is not well supported in the literature, and studies that show benefit from use of the interferential stimulator are not well designed to clearly demonstrate cause and effect. The guidelines support the use of an interferential stimulator for a one-month trial to determine if this treatment modality leads to increased functional improvement, less reported pain and medication reduction. The request is not for a one-month trial however, and the unit and NMES is not recommended by the guidelines. As the request for the Interferential unit x 3 months home use is determined to not be medically necessary, there is no indication for a garment purchase to be used with the device. Therefore, the request for garment purchase is not medically necessary.

LSO back brace - Lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods.

Decision rationale: Per the MTUS Guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The clinical documents do not report an acute injury that may benefit from short-term use of a lumbar support for symptom relief. The MTUS Guidelines do not indicate that the use of a lumbar spine brace would improve function. Therefore, the request for LSO back brace - lumbar is not medically necessary.