

Case Number:	CM15-0051657		
Date Assigned:	03/25/2015	Date of Injury:	12/04/2012
Decision Date:	05/01/2015	UR Denial Date:	03/05/2015
Priority:	Standard	Application Received:	03/18/2015

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: Pennsylvania

Certification(s)/Specialty: Internal 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 22 year old male who sustained an industrial injury on 12/4/12. He has reported initial symptoms of low back, right hip, left upper leg pain. The injured worker was diagnosed as having lumbosacral sprain/strain, bilateral sacroiliac joint sprain, and lumbar radiculitis. Treatments to date included medication, bracing, chiropractic treatment, physical therapy, home exercise program, and surgery (L4-5 and L5-S1 laminectomy and discectomy). Magnetic Resonance Imaging (MRI) of the lumbar spine on 10/22/14 showed L4-5 loss of disc space signal, right hemilaminectomy changes, moderate facet hypertrophy, and a 3-4 mm residual or recurrent disc protrusion indenting the thecal sac, with possibly of an annular tear, L5-S1 loss of disc space signal and approximately 4 mm right sided disc herniation indenting the thecal sac, missing bone left L5 lamina and left L5 inferior articular facet. A prescription for interferential (IF) stimulator from August 2014 for an additional 3 months was present in the documentation submitted. There was no documentation of the actual duration of use of and outcome of use of the interferential stimulator. A partially legible note from 11/6/14 notes temporary pain relief from home IF unit. Medications from November 2014 to February 2015 included norco, fexmid, and anaprox. Currently, the injured worker complains of low back pain with left lower extremity radiating pain below the knee. The treating physician's report (PR-2) from 1/27/15 indicated tender paraspinals with spasm. It was noted that the injured worker was currently working usual and customary duties. Treatment plan included purchase of Interferential (IF) stimulator unit, electrode packs, power packs, leadwire, adhesive remover, towel mint, and

shipping and handling. On 3/5/15, Utilization Review (UR) non-certified requests for purchase of IF unit and associated supplies, citing the MTUS.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of IF stimulator unit, provided on date of service: 10/09/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines transcutaneous electrotherapy, interferential current stimulation Page(s): 118-120.

Decision rationale: Per the MTUS, interferential current stimulation 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. There are no standardized protocols for the use of interferential stimulation. If certain criteria are met, a one month trial may be appropriate to permit the physician and physical medicine provider to determine effects and benefits. Criteria include pain which is ineffectively controlled by medications, history of substance abuse, pain from postoperative conditions that limit the ability to perform exercise programs, or lack of response to conservative measures. After the one month trial, continued use is contingent upon evidence of increased functional improvement, less reported pain and evidence of medication reduction. In this case, the injured worker had chronic back pain and was prescribed an IF stimulator unit. The documentation suggests that a trial was performed around August of 2014, although the specific dates, duration, and outcome of the use of the IF stimulator were not documented. The injured worker was noted to be working since August 2014; it was unclear if the return to work occurred before or after the use of the IF unit. There was no discussion of increase in specific activities of daily living as a result of the use of the IF stimulator unit. There was no documentation of decrease in medication use or decrease in frequency of office visits. Due to lack of demonstration of functional improvement, decrease in pain, and evidence of medication reduction, the request for Purchase of IF stimulator unit, provided on date of service: 10/09/2014 is not medically necessary.

Purchase of electrodes packs, QTY: 12 for 3 months, provided on date of service: 10/09/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines transcutaneous electrotherapy, interferential current stimulation Page(s): 118-120.

Decision rationale: The injured worker was prescribed an IF stimulator unit, which has been determined to be not medically necessary. This requested item is prescribed in association with the IF stimulator unit. As such, it is not medically necessary.

Purchase of power packs, QTY: 36 for 3 months, provided on date of service: 10/09/2014:
Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines transcutaneous electrotherapy, interferential current stimulation Page(s): 118-120.

Decision rationale: The injured worker was prescribed an IF stimulator unit, which has been determined to be not medically necessary. This requested item is prescribed in association with the IF stimulator unit. As such, it is not medically necessary.

Purchase of leadwire, QTY: 1 for 3 months, provided on date of service: 10/09/2014:
Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines transcutaneous electrotherapy, interferential current stimulation Page(s): 118-120.

Decision rationale: The injured worker was prescribed an IF stimulator unit, which has been determined to be not medically necessary. This requested item is prescribed in association with the IF stimulator unit. As such, it is not medically necessary.

Purchase of adhesive remover, towel mint, QTY: 48 for 3 months, provided on date of service: 10/09/2014: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines transcutaneous electrotherapy, interferential current stimulation Page(s): 118-120.

Decision rationale: The injured worker was prescribed an IF stimulator unit, which has been determined to be not medically necessary. This requested item is prescribed in association with the IF stimulator unit. As such, it is not medically necessary.

Shipping and handling, provided on date of service 10/09/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines transcutaneous electrotherapy, interferential current stimulation Page(s): 118-120.

Decision rationale: The injured worker was prescribed an IF stimulator unit, which has been determined to be not medically necessary. This requested item is prescribed in association with the IF stimulator unit. As such, it is not medically necessary.