

Case Number:	CM15-0055827		
Date Assigned:	03/26/2015	Date of Injury:	07/25/2011
Decision Date:	05/01/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/24/2015

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:

The injured worker is a 56-year-old male, who sustained an industrial injury on 07/25/2011. He reported an injury to his lower back. The injured worker is currently diagnosed as having cervical fusion, lumbar intervertebral disc disorder with myelopathy, cervical intervertebral disc disorder with myelopathy, sciatica, and failed lumbar epidural injection. Treatment to date has included cervical fusion, cervical MRI, lumbar epidural injection, and medications. In a progress note dated 02/13/2015, the injured worker presented with complaints of left cervical, cervical, right cervical, right anterior shoulder, left anterior shoulder, right anterior arm, right anterior elbow, right anterior forearm, right anterior hand, right anterior wrist, left anterior arm, left anterior elbow, left anterior forearm, left anterior wrist, left anterior hand, left lumbar, left sacroiliac, lumbar, right lumbar, right sacroiliac, left buttock, left posterior leg, left posterior knee, left calf, left ankle, left foot, right buttock, right posterior leg, right posterior knee, right calf, right ankle, and right foot pain. The treating physician reported requesting authorization for a home interferential stimulator unit for chronic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

One Interferential Stimulator Home Unit > 90 days, for initial 60 days: 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 Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The claimant is nearly 4 years status post work-related injury and continues to be treated for chronic widespread pain. Criteria for continued 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. A two month trial with total rental of three months is being requested which is not medically necessary.