MAXIMUS Federal Services

Case Number:	CM15-0068333		
Date Assigned:	05/20/2015	Date of Injury:	12/07/2014
Decision Date:	07/07/2015	UR Denial Date:	03/17/2015
Priority:	Standard	Application Received:	04/10/2015

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: 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 30-year-old male with an industrial injury dated 12/07/2014. Diagnoses included sciatica and low back pain. Prior treatments include injection for pain (Toradol). He presents on 01/02/2015 (most current record available) with complaints of continued low back pain radiating to back of legs. Objective findings are not documented. Treatment plan included continuing ibuprofen, light duty and light to moderate walking at the gym. The physician is requesting physical therapy and one interferential unit. (Available records do not elaborate on complaints and findings.)

IMR ISSUES, DECISIONS AND RATIONALES

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

One interferential unit: 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 Page(s): 118-120.

Decision rationale: The patient presents on 03/24/15 with lower back pain which radiates into the buttocks and associated numbness in the bilateral lower extremities. The patient's date of injury is 12/07/14. Patient has no documented surgical history directed at this complaint. The request is for 1 INTERFERRENTIAL UNIT. The RFA is dated 03/24/15, though does not include the request for an IF unit. Physical examination dated 03/24/15 reveals tenderness to palpation of the lumbar spine with spasms noted, positive straight leg raise bilaterally, and decreased "patchy" sensation in the bilateral lower extremities with decreased deep tendon reflexes noted. The patient is currently prescribed any medications. Diagnostic imaging included MRI of the lumbar spine dated 12/26/14, significant findings include: "Focal degenerative disc disease at L4-L5 with broad-based disc bulge and anterior thecal sac impingement." Per 03/24/15 progress note, patient is classified as temporarily totally disabled for 4-6 weeks. MTUS Chronic Pain Medical Treatment Guidelines, pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or; Pain is ineffectively controlled with medications due to side effects; or; History of substance abuse; or; Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or; Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person." In regard to what appears to be a purchase of an IF unit for this patient's lower back pain, evidence of a successful 30 day trial has not been provided. There is no evidence that this patient has trialed an IF unit to date. Were the request for a 30 day rental or trial the recommendation would be for approval. However, a purchase or unspecified rental of an IF unit does not meet MTUS guideline procedures and cannot be substantiated. Therefore, the request IS NOT medically necessary.