

Case Number:	CM14-0212477		
Date Assigned:	01/02/2015	Date of Injury:	06/27/2012
Decision Date:	03/03/2015	UR Denial Date:	12/11/2014
Priority:	Standard	Application Received:	12/18/2014

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 patient is a 44 year old male with date of injury 06/27/12. The treating physician report dated 11/12/14 (16) indicates that the patient presents with pain affecting the low back. The patient describes the pain as achy, sharp, burning and throbbing, traveling to the bilateral lower extremities with numbness and tingling sensation. The physical examination findings reveal a restricted range of motion of the lumbar spine. Lateral bending is limited to 15 degrees bilaterally, flexion is limited to 60 degrees, and extension is limited to 20 degrees. Further examination reveals sensation is intact to pain, temperature, light touch, vibration and two-point discrimination in the right L1, L2, and L3 dermatomes, otherwise decreased in the bilateral L4, L5, and S1 dermatomes. Prior treatment history includes physical therapy, chiropractic therapy, rest and home exercise program, and prescribed medications. The current diagnoses are: 1. Lumbar disc disease 2. Lumbar radiculopathy 3. Lumbar facet syndrome The utilization review report dated 12/11/14 (8) denied the request for Interferential unit - 30 day rental for home use based on a lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential unit - 30 day rental for home use: Overturned

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): 118-1120.

Decision rationale: The patient presents with pain affecting the low back. The current request is for Interferential unit - 30 day rental for home use. The treating physician report dated 11/12/14 (22) states, "The patient has failed conservative treatment including physical therapy, chiropractic manipulative therapy, medication, rest and home exercise program of more than 6 over the last 12 months." MTUS (p118-120) states "Interferential Current Stimulation (ICS) 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.)." In this case, there is no indication that the patient has ever received an Interferential unit previously, and prior conservative treatment has failed to treat the patient's symptoms. The current request of a one month trial satisfies the MTUS guidelines as outlined on pages 118-120. Therefore, the requested unit is medically necessary and appropriate.