

Case Number:	CM14-0213143		
Date Assigned:	12/30/2014	Date of Injury:	02/12/2003
Decision Date:	03/09/2015	UR Denial Date:	12/05/2014
Priority:	Standard	Application Received:	12/19/2014

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: Texas, Florida

Certification(s)/Specialty: Anesthesiology, 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 50 year old male with a date of injury of February 10, 2003. Results of the injury include the lumbar spine. Diagnosis include T/L spine s/s B le RAO, Left wrist STR, and neuro-Geiber. Treatment has included medications management with Ambien, Tramadol and Motrin. The patient is utilizing lumbar support. Magnetic resonance imaging (MRI) scan dated June 10, 2013 revealed lumbar spondylosis. Progress report dated October 14, 2014 showed lumbar spine tenderness more so on the left and positive straight leg raising test The pain score was noted as 7/1- with medications and 9/10 without medications on a 0 to 10 scale. The patient also complained of muscle spasm, stress and heartburn. There was asymmetric motion loss. Work status was noted as modified. The treatment plan included medication refills and replacement of the Interferential Unit which was noted to be more than 3 years old. There was no documentation of the functional beneficial effect of the Unit. Utilization review form dated December 5, 2014 non certified interferential simulator unit due to noncompliance with MTUS guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Stimulator Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines Muscle Relaxants for Pain, TENS, ICS.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 171,Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 118.

Decision rationale: The CA MTUS recommend that Interferential Unit can be utilized in conjunction with other treatment measures such as PT, RTW programs in the management of musculoskeletal pain.The records indicate that the patient had an Interferential Unit available for more than 3 years. There is no documentation of utilization of the unit. There is no documentation of compliance with treatment with PT/RTW programs. The records did not specify why a new Interferential unit is required for the treatment of the low back pain. The patient is utilizing medications management. The criteria for the Interferential Stimulator Unit was not met.