

Case Number:	CM15-0092485		
Date Assigned:	05/18/2015	Date of Injury:	08/22/2012
Decision Date:	07/03/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/13/2015

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 60 year old female, who sustained an industrial/work injury on She reported initial complaints of low back pain and right hip pain. The injured worker was diagnosed as having intractable back pain with lumbar herniated nucleus pulposus, spinal stenosis, enthesopathy of hip region, and arthritis of the hip. Treatment to date has included medication, activity modification, stretching, and diagnostics. MRI results were reported on 11/29/12 that revealed left paracentral posterior disc protrusion at T11-12, T12-L1 indenting the anterior aspect of the thecal sac, desiccation at level L1-2, L2-3, L3-4, and L4-5, and L5-S1. X-Rays results of the spine were reported loss of lordosis suggestive of paraspinal spasms, disc space narrowing at L5-S1, mild spondylosis and no acute fracture, spondylolisthesis, and intersegmental instability. Currently, the injured worker complains of constant stabbing throbbing, and sharp pain to the low back and right hip. Per the primary physician's progress report (PR-2) on 4/1/15, there was tenderness with palpation to the thoracolumbar region, mild paraspinal spasms and limited range of motion. Current plan of care included continuation of medication and start ART unit to the affected area. The requested treatments include ART unit purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

ART unit purchase times one: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: This patient presents with constant stabbing, throbbing, and sharp pain in the low back and right shoulder pain. The current request is for ART unit purchase times one. The Request for Authorization is dated 02/10/15. The patient's work status is modified duties and work accommodation needed. MTUS 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." The treating physician has recommended the purchase of an ART unit to "apply to affected area for pain, swelling, and spasm control." There is no documentation of substance abuse, operative condition, nor unresponsiveness to conservative measures. Documentation to support the criteria for an IF unit has not been met. Furthermore, MTUS requires a 30-day trial of the unit showing pain and functional benefit before a home unit is allowed. The current request is for purchase; therefore, recommendation cannot be made. This request is not medically necessary.