

Case Number:	CM14-0007392		
Date Assigned:	02/10/2014	Date of Injury:	10/11/1995
Decision Date:	06/23/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/21/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 70 year old female whose date of injury is 10/11/1995. The injured worker reportedly sustained a cumulative trauma injury to the cervical and lumbar spine. The report dated 06/03/13 indicates that she has been experiencing worsening pain in her low back radiating into her left lower extremity. Diagnosis is lumbar musculoligamentous sprain/strain with left lower extremity radiculitis and multilevel facet arthropathy, grade I anterolisthesis of L4 on L5, slight degenerative changes in the bilateral sacroiliac joints and mild central and left lateral recess stenosis at L5-S1, per MRI scan dated 09/11/11.

IMR ISSUES, DECISIONS AND RATIONALES

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

ORTHOSTIM/TEAR TECH STIMULATOR SYSTEM (RENTAL/PURCHASE) AND SUPPLIES FOR LUMBAR SPINE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

Decision rationale: Based on the clinical information provided, the request for Orthostim/tear tech stimulator system (rental/purchase) and supplies for lumbar spine is not recommended as

medically necessary. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The submitted records fail to establish that the injured worker has undergone a recent successful trial of the unit to establish efficacy of treatment as required by the California Medical Treatment Utilization Schedule (CA MTUS) guidelines. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals were provided as required by the California Medical Treatment Utilization Schedule (CA MTUS) guidelines. Therefore the request is not medically necessary or appropriate.