

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0100074 | | |
| Date Assigned: | 06/02/2015 | Date of Injury: | 07/18/2014 |
| Decision Date: | 10/08/2015 | UR Denial Date: | 05/19/2015 |
| Priority: | Standard | Application Received: | 05/26/2015 |

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 50 year old male injured worker suffered an industrial injury on 07/18/2014. The diagnoses included lumbosacral musculoligamentous sprain/strain with right lower extremity radiculitis along with herniated disc and right sacroiliac joint sprain. The diagnostics included lumbar magnetic resonance imaging. The injured worker had been treated with physical therapy and medications. On 5/13/2015, the treating provider reported low back pain radiating to the right leg with associated numbness and tingling. On exam there was tenderness of the lumbar muscles and sacroiliac joint with guarding. The straight leg raise was positive with reduced range of motion to the lumbar spine The treatment plan included AVID Interferential stimulator, Electrodes packs, 12 Power packs, 15 adhesive remover towel, 1 TT & SS lead wire and 1 Tech fee.

IMR ISSUES, DECISIONS AND RATIONALES

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

AVID Interferential Stimulator (1-month rental): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: This patient presents with chronic low back pain with right lower extremity radiculitis. The current request is for AVID Interferential stimulator 1 month rental. The RFA is dated 05/18/15. Treatment history includes physical therapy, modified work, and medications. The patient is TTD. 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." According to progress report 05/13/15, the patient reported low back pain. Examination of the lumbar spine revealed tenderness to palpation and muscle guarding present over the paravertebral musculature and lumbosacral junction. Positive straight leg raise, Yeoman's and Gaenslen's tests were noted. The patient has completed a course of 8 PT sessions with some benefit. The treater recommended additional PT, medications and an IF unit to help alleviate pain and muscle spasm. In this case, failure of medications is not documented and it appears that the patient found some success through physical therapy. There is no evidence that pain is not effectively controlled due to the ineffectiveness of medication, substance abuse, pain due to postoperative conditions or unresponsiveness to conservative measures as required by MTUS for an IF unit trial; therefore, the request IS NOT medically necessary.

Electrodes Packs, #4 (1-month supply): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: This patient presents with chronic low back pain with right lower extremity radiculitis. The current request is for Electrodes packs 1 month supply. The RFA is dated 05/18/15. Treatment history includes physical therapy, modified work, and medications. The patient is TTD. 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." According to progress report 05/13/15, the patient reported low back pain. Examination of the lumbar spine revealed tenderness to palpation and muscle guarding present over the paravertebral musculature and lumbosacral junction. Positive straight leg raise, Yeoman's and Gaenslen's tests were noted. The patient has completed a course of 8 PT sessions with some benefit. The treater recommended additional PT, medications and an IF unit to help alleviate pain and muscle spasm. In this case, failure of medications is not documented and it appears that the patient found some success through physical therapy. There is no evidence that pain is not effectively controlled due to the ineffectiveness of medication, substance abuse, pain due to postoperative conditions or unresponsiveness to conservative measures. The patient does not meet the indication for an IF unit; therefore the requested supplies to be used in conjunction with the unit IS NOT medically necessary.

Power Packs, #12 (1-month supply): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: This patient presents with chronic low back pain with right lower extremity radiculitis. The current request is for 12 Power packs 1 month supply. The RFA is dated 05/18/15. Treatment history includes physical therapy, modified work, and medications. The patient is TTD. 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." According to progress report 05/13/15, the patient reported low back pain. Examination of the lumbar spine revealed tenderness to palpation and muscle guarding present over the paravertebral musculature and lumbosacral junction. Positive straight leg raise, Yeoman's and Gaenslen's tests were noted. The patient has completed a course of 8 PT sessions with some benefit. The treater recommended additional PT, medications and an IF unit to help alleviate pain and muscle spasm. In this case,

failure of medications is not documented and it appears that the patient found some success through physical therapy. There is no evidence that pain is not effectively controlled due to the ineffectiveness of medication, substance abuse, pain due to postoperative conditions or unresponsiveness to conservative measures. The patient does not meet the indication for an IF unit; therefore the requested supplies to be used in conjunction with the unit IS NOT medically necessary.

Adhesive Remover Towel Mint, #15 (1-month supply): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: This patient presents with chronic low back pain with right lower extremity radiculitis. The current request is for 15 adhesive remover towel mint. The RFA is dated 05/18/15. Treatment history includes physical therapy, modified work, and medications. The patient is TTD. 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." According to progress report 05/13/15, the patient reported low back pain. Examination of the lumbar spine revealed tenderness to palpation and muscle guarding present over the paravertebral musculature and lumbosacral junction. Positive straight leg raise, Yeoman's and Gaenslen's tests were noted. The patient has completed a course of 8 PT sessions with some benefit. The treater recommended additional PT, medications and an IF unit to help alleviate pain and muscle spasm. In this case, failure of medications is not documented and it appears that the patient found some success through physical therapy. There is no evidence that pain is not effectively controlled due to the ineffectiveness of medication, substance abuse, pain due to postoperative conditions or unresponsiveness to conservative measures. The patient does not meet the indication for an IF unit; therefore the requested supplies to be used in conjunction with the unit IS NOT medically necessary.

TT & SS Lead Wire, #1 (1-month supply): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: This patient presents with chronic low back pain with right lower extremity radiculitis. The current request is for 1 TT & SS lead wire. The RFA is dated 05/18/15. Treatment history includes physical therapy, modified work, and medications. The patient is TTD. 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." According to progress report 05/13/15, the patient reported low back pain. Examination of the lumbar spine revealed tenderness to palpation and muscle guarding present over the paravertebral musculature and lumbosacral junction. Positive straight leg raise, Yeoman's and Gaenslen's tests were noted. The patient has completed a course of 8 PT sessions with some benefit. The treater recommended additional PT, medications and an IF unit to help alleviate pain and muscle spasm. In this case, failure of medications is not documented and it appears that the patient found some success through physical therapy. There is no evidence that pain is not effectively controlled due to the ineffectiveness of medication, substance abuse, pain due to postoperative conditions or unresponsiveness to conservative measures. The patient does not meet the indication for an IF unit; therefore the requested supplies to be used in conjunction with the unit IS NOT medically necessary.

Tech Fee: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: This patient presents with chronic low back pain with right lower extremity radiculitis. The current request is for TECH FEE. The RFA is dated 05/18/15. Treatment history includes physical therapy, modified work, and medications. The patient is TTD. According to progress report 05/13/15, the patient reported low back pain. Examination of the lumbar spine revealed tenderness to palpation and muscle guarding present over the paravertebral musculature and lumbosacral junction. Positive straight leg raise, Yeoman's and Gaenslen's tests were noted. The patient has completed a course of 8 PT sessions with some benefit.

The treater recommended additional PT, medications and an IF unit to help alleviate pain and muscle spasm. The request is for IF unit, electrodes, pads, adhesive, lead wire and tech fee. In this case, failure of medications is not documented and it appears that the patient found some success through physical therapy. There is no evidence that pain is not effectively controlled due to the ineffectiveness of medication, substance abuse, or post op pain. The patient does not meet the indication for an IF unit; therefore the requested tech fee that is requested in conjunction with the IF unit IS NOT medically necessary.