

Case Number:	CM13-0045147		
Date Assigned:	12/27/2013	Date of Injury:	07/09/2011
Decision Date:	02/27/2014	UR Denial Date:	10/07/2013
Priority:	Standard	Application Received:	11/01/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 physician 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:

This patient is a 56-year old female with a history of injury from 7/9/11. The mechanism/cause of injury is not seen in the submitted documentation, but the patient has multiple diagnoses that include right shoulder periscapular strain with impingement, biceps tenosynovitis, subacromial bursitis, lumbar sprain/strain, bilateral lower extremity radiculitis, severe L4-L5 degenerative disc disease, bilateral facet degenerative changes, and gastrointestinal symptoms secondary to use of chronic medications. The patient was seen by [REDACTED] on 9/27/13. At that time, the patient was complaining of low back pain with radicular features as well as right shoulder pain. [REDACTED] does not state that pain is ineffectively controlled with medications, that the patient has a history of substance abuse, is unresponsive to conservative measures, or is status post-operative. After this visit, it appears that a request for an Interferential Stimulation unit was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Two month rental of Interferential Stimulation unit and purchase of supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-119.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy/Interferential Current Stimulation Page(s): 118-119.

Decision rationale: Interferential Stimulation units are not recommended as an isolated intervention, but may be appropriate for a trial (defined as 1-month), if the pain is ineffectively controlled by medications due to side effects or diminished effectiveness, if there is a history of substance abuse, if the patient is unresponsive to conservative measures, or the patient has significant post-operative pain and is limited in the ability to perform physical therapy/exercise. In this case, the requesting provider does not provide any clinical details that meet these criteria. In addition, the request for a 2 month trial exceeds the trial duration as defined by the guidelines of 30 days. Therefore, the requested unit rental and supplies are not medically necessary or appropriate.