

Case Number:	CM14-0001879		
Date Assigned:	01/24/2014	Date of Injury:	03/27/2012
Decision Date:	06/20/2014	UR Denial Date:	12/12/2013
Priority:	Standard	Application Received:	01/07/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine 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 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 32-year-old male with a reported date of injury of 05/15/2012. The mechanism of injury was not submitted in the medical records. The progress note dated 08/07/2013 listed the surgery on 01/08/2013 as a right knee scope, a partial medial meniscectomy, grade II to III MFC, grade II trochlea and patella. The medications listed on the progress note were Naprosyn and Vicodin. The injured worker underwent surgical intervention to the right knee on 01/08/2013. The progress note reported that the injured worker was not taking medication for the knee pain and described it as dull, aching and frequent and aggravated by bending. The diagnoses listed on the progress note are a medial meniscus tear, knee pain, chondromalacia and synovitis to the knee. The Request for Authorization was not submitted within the medical records. The request was for a retrospective request for an interferential stimulator (IF unit) for a quantity of 1 and dated 11/18/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

**RETROSPECTIVE REQUEST FOR INTERFERENTIAL STIMULATOR (IF UNIT)
QTY: 1.00 DOS 11/18/13: Upheld**

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ACOEM PRACTICE GUIDELINES , INTERFERENTIAL

CURRENT STIMULATION, NEUROMUSCULAR ELECTRICAL STIMULATION, TENS.
UPDATED CHRONIC PAIN CHAPTER, 118, 189

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guideline Interferential Current Stimulation (ICS), Page(s): 18-1.

Decision rationale: The request for a retrospective request for an interferential stimulator (IF unit) dated 11/18/2013 is not medically necessary. The request is for 12 months of therapy with the interferential stimulator. The Chronic Pain Medical Treatment Guidelines do not recommend the interferential stimulator as an isolated intervention. The guidelines also state that there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications and limited evidence of improvement on those recommended treatments alone. The guideline criteria for interferential stimulation to be used are that pain is ineffectively controlled due to diminished effectiveness of medications; pain is ineffectively controlled with medications due to side effects or a history of substance abuse; or significant pain for postoperative conditions limit the ability to perform an exercise program/physical therapy treatment, or unresponsiveness to conservative measures, such as repositioning or heat/ice. The guidelines recommend that if the criteria are met, then a 1 month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. The guidelines also state that there should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. The progress notes stated that the injured worker is no longer taking medications for the knee pain and that he was involved in the physical therapy at the time of the request. The request form did mention the use of 12 months for the interferential stimulation device. The guidelines also recommend a 1 month trial following all criteria being met; it was unclear if the injured worker has undergone a one month trial with documented efficacy. There is a lack of documentation supporting the need for an interferential stimulator based on the criteria. Therefore, the request is not medically necessary.