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| Case Number: | CM14-0008037 | | |
| Date Assigned: | 02/12/2014 | Date of Injury: | 10/21/2011 |
| Decision Date: | 07/03/2014 | UR Denial Date: | 01/03/2014 |
| 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 Occupational 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 patient is a 58-year-old who has submitted a claim for bilateral elbow pain and right wrist pain, associated with an industrial injury date of October 21, 2011. Medical records from 2013 through 2014 were reviewed. The progress report, dated May 13 2013, showed bilateral elbow pain and right wrist pain. The right hand was associated with numbness and tingling sensation. Physical examination revealed tenderness of bilateral elbows. Range of motion was not limited but pain was noted with resisted test of the wrist and finger extensors bilaterally. Tinel's test and Phalen's test were positive on the right. There were no reported sensory deficits. Treatment to date has included unspecified date of left elbow surgery and medications such as Ultram, Flexeril and topical creams since 2013. Utilization review from January 3, 2014 denied the request for interferential unit because there was 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.

IMR ISSUES, DECISIONS AND RATIONALES

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

INTERFERENTIAL UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, interferential current stimulation is not recommended as an isolated intervention. 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. In this case, the medical reviews showed the patient was cleared to work without restrictions. Medications were likewise prescribed, such as Ultram, Flexeril and topical creams. Chronic Pain Medical Treatment Guidelines criteria for use of interferential unit have been met. However, the duration of use, and if the device is for rental or purchase were not specified. In addition, there is no evidence that an interferential unit will be employed in the context of an overall regimen. The request for an interferential unit is not medically necessary or appropriate.