

Case Number:	CM14-0107552		
Date Assigned:	08/01/2014	Date of Injury:	04/01/2014
Decision Date:	12/31/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/11/2014

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 Management 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 49 year old male who sustained several work related injury dating back to August 24, 1990 to his lower back, right shoulder, upper back, neck region and left shoulder according to the doctor's first report of occupational injury. As of April 1, 2014, the injured worker continued his usual work duties as deputy sheriff despite increasing pain and inability to run for physical training due to cumulative effects. The doctor's first report of occupational injury neurological examination noted sensory intact without muscle weakness in all four extremities. Cervical spine films were normal. Lumbar films noted facetectomy degenerative changes on the right lumbar 2-3 and lumbar4-5 levels. Right and left shoulder films revealed minimal acromioclavicular degenerative joint changes. Right shoulder arthroscopy was performed in 2007. The diagnoses consist of musculoligamentous sprain/strain to the cervical, thoracic and lumbar regions, bilateral upper and lower extremity radiculitis and bilateral periscapular shoulder strain with bursitis/tendinitis. The patient reports occasional flare ups of the lower back symptoms with increasing pain in the lower back radiating bilaterally with numbness and tingling to the feet, left side worse than right and bilateral shoulder and neck pain with numbness and tingling of hands bilaterally. No medications were noted. The injured worker continues his customary duties at work. The treating physician has requested a two month rental of Interferential Stimulator with supplies. (Supplies consist of 8 pack electrodes, 24 power packs, 32 adhesive remover towel mint, 1 shipping and handling, 1 lead wire and tech fit with instructions). On June 16, 2014 the Utilization Review non-certified the prescription for the 2 month rental of Interferential Stimulator with supplies. (Supplies consist of 8 pack electrodes, 24 power packs, 32 adhesive remover towel mint, 1 shipping and handling, 1 lead wire and tech fit with instructions) based on no documentation of prior use, trial response and no discussion of an exercise program in place. Citations used in the decision process were the Official Disability

Guidelines (ODG) -Treatment in Workman's Compensation (TWC) Neck and Upper Back Procedure Summary, Shoulder Procedure Summary and Low Back Procedure Summary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Stimulator with supplies times 2 months (8 packs electrodes, 24 power packs, 32 adhesive remover towel mint, 1 shipping and handling, 1 lead wire and tech fit with instructions): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Neck and Upper Back Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120 of 127.

Decision rationale: Regarding the request for Interferential Stimulator with Supplies times 2 months (8 packs electrodes, 24 power packs, 32 adhesive remover towel mint, 1 shipping and handling, 1 lead wire and tech fit with instructions), CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested Interferential Stimulator with Supplies times 2 months (8 packs electrodes, 24 power packs, 32 adhesive remover towel mint, 1 shipping and handling, 1 lead wire and tech fit with instructions) is not medically necessary.