

Case Number:	CM14-0013243		
Date Assigned:	02/26/2014	Date of Injury:	05/27/2011
Decision Date:	08/05/2014	UR Denial Date:	01/29/2014
Priority:	Standard	Application Received:	02/03/2014

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:

This is a 38-year-old with a May 27, 2011 date of injury after a slip and fall injuring the head, wrist, left elbow, and back. The patient was seen on October 28, 2013 complaining of neck and back pain with radiation to the ankle. Exam findings revealed tenderness to the L and C spine and paraspinal spasm with limited range of motion. Straight leg raise was positive bilaterally. The diagnosis is chronic cervical strain, and chronic lumbar strain with radiculopathy. Treatment to date: physical therapy, acupuncture, medications, and epidurals. A UR decision dated January 29, 2014 denied the request for unspecified reasons.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inter-Spec IF (Interferential Stimulation) II unit: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that a one-month trial may be appropriate when 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. This patient had a low back injury in 2011 resulting in low back pain with radiculopathy. However, there has been no adequate documentation regarding conservative pain control measures such as physical therapy, exercise programs, or an inability of pain control secondary to side effects. In addition, there is inadequate documentation regarding the results of a one month trial of an IF unit. Therefore, the request for the Inter-Spec IF (Interferential Stimulation) II unit is not medically necessary or appropriate.

Monthly supply purchase for Inter-Spec IF (Interferential Stimulation) II unit: Upheld

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

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

Decision rationale: Since the primary equipment is not medically necessary, none of the associated parts are medically necessary.