

<b>Case Number:</b>	CM14-0018285		
<b>Date Assigned:</b>	04/21/2014	<b>Date of Injury:</b>	09/09/2011
<b>Decision Date:</b>	07/01/2014	<b>UR Denial Date:</b>	01/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2014

### 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 Family Medicine and is licensed to practice in Arizona. 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 51-year-old female with a date of injury on 9/9/2011. The diagnoses include cervical sprain, cervical intervertebral disc displacement, thoracic sprain, lumbar disc displacement, and wrist sprain. The current subjective complaints are of pain in her hand getting worse, and awaking with numbness in the hand. The patient also reported she had not received her medications. Physical exam documents reveal restricted mobility in bilateral hands. The treatment plan from 1/17/14 visit was for a refill of Flector patches, discontinuation of Diclofenac, and refill for interferential unit electrodes. The submitted documentation does not give any reference to previous efficacy or duration of interferential therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**REFILL OF IF UNIT ELECTRODES:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL THERAPY Page(s): 118.

**Decision rationale:** The CA MTUS 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. Possibly appropriate for the following conditions if it proven to be effective when applied by the physician or a provider licensed to provide physical medicine: 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 unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. For this patient, there is no evidence of previous benefit with interferential unit usage, and there is no evidence of medications being ineffective, as documentation states patient had not been using medications. Therefore, the medical necessity of an interferential device and associated medical supplies is not established.