

Case Number:	CM14-0143661		
Date Assigned:	09/12/2014	Date of Injury:	05/29/2010
Decision Date:	12/16/2014	UR Denial Date:	08/13/2014
Priority:	Standard	Application Received:	09/04/2014

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 Practice and is licensed to practice in Texas and Mississippi. 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 54-year-old female who reported an injury on 05/29/2010. The mechanism of injury was a slip and fall. Her diagnoses included cervical and lumbar spine strain, left knee strain, status post right knee and right shoulder surgery. Her past treatments included physical therapy and medications. Diagnostic studies included x-rays of the cervical spine on 03/17/2014 and a negative electrodiagnostic study on 04/17/2011. Her surgery history included right knee and right shoulder surgery on unspecified dates. The progress report dated 08/13/2014 indicated the injured worker complained of pain to the neck, right shoulder, and bilateral knees. She also complained of loss of bladder control. Physical examination revealed diminished sensation to light touch to the right mid anterior thigh, mid lateral calf, and the lateral ankle. Her medications included gabapentin, Trazodone, Gaviscon and Nexium. The request was for an interferential stimulator. The rationale for the request and the Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: The request for an interferential stimulator (IF unit) is not medically necessary. The California MTUS Guidelines do not recommend interferential current stimulation as an isolated intervention but could possibly be appropriate if pain is ineffectively controlled due to diminished effectiveness of medications or side effects, history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercise program/physical therapy treatment, or unresponsive to conservative measures (eg, repositioning, heat/ice, etc.). The treating provider failed to provide a treatment plan that demonstrated the plan of use for the unit and included the adjunct treatments to be provided in conjunction with the interferential stimulator unit. There was a lack of documentation to demonstrate extreme factors to warrant medical necessity for the request, such as the aforementioned conditions. Therefore, the request for an interferential stimulator (IF unit) is not medically necessary.