MAXIMUS Federal Services

Case Number:	CM14-0172096		
Date Assigned:	10/23/2014	Date of Injury:	03/28/2006
Decision Date:	11/21/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	10/17/2014

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 Emergency 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 injured worker is a 47-year-old male who reported an injury on 03/28/2006. The mechanism of injury was not submitted for clinical review. The diagnoses included bilateral shoulder sprain/strain and lumbosacral radiculopathy. The previous treatments included medication. Within the clinical note dated 11/28/2012, it was reported the patient complained of increased pain. Upon the physical examination, the provider noted the bilateral shoulders had tenderness with painful range of motion. Forward flexion was noted to be 150 degrees and abduction 145 degrees bilaterally. There was positive spasm to the lumbar spine. The request was for an inferential (IF) unit and supplies for purchase. However, the rationale was not submitted for clinical review. The Request for Authorization was submitted and dated 12/11/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: Interferential Stimulator (IF Unit) and supplies-purchase with one year supply, date of service: 6/27/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

Decision rationale: The retrospective request for an Interferential Stimulator (IF Unit) and supplies-purchase with one year supply, date of service: 6/27/13, is not medically necessary. The California MTUS Guidelines do not recommend a stim care unit 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 for those recommended treatments alone. It may possibly be appropriate for the following conditions if documented, that pain is ineffectively controlled due to diminished effectiveness of medication, pain is ineffectively controlled with medications due to side effects and there is a history of substance abuse, significant pain from postoperative conditions which limits the ability to perform exercise programs/physical therapy treatments, or unresponsive conservative treatment measures. There is a lack of documentation provided that would reflect diminished effectiveness of medications or a history of substance abuse or any postoperative conditions which would limit the injured worker the inability to perform in an exercise program. There is a lack of documentation indicating the injured worker had tried and failed on conservative therapy. Additionally, there is a lack of recent clinical documentation warranting the medical necessity for the request. Therefore, the request is not medically necessary.