

Case Number:	CM14-0174996		
Date Assigned:	10/28/2014	Date of Injury:	04/24/2013
Decision Date:	12/12/2014	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	10/23/2014

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 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 58 year-old man who was injured at work on 4/24/2013. The injury was primarily to his left wrist. He is requesting review of denial for an "Interferential Stimulator (IF Unit) Rental for the Left Wrist." Medical records corroborate ongoing care for his injury. His chronic diagnosis is: Left Wrist Internal Derangement. He underwent an Orthopedic Evaluation on 9/29/2014. The patient had undergone a course of Motrin without substantial relief. Radiographs of the wrist showed "evidence of prior scaphoid fracture/question nonunion and radiocarpal joint space narrowing." The assessment was "Probable SLAC (Scaphoid Lunate Advanced Collapse) and it was recommended that he be assessed by a hand specialist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Stimulator (IF Unit) Rental for The Left Wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines IF Unit.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrostimulation Page(s): 114-121.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of transcutaneous electrotherapy for the treatment of certain conditions. Within these

guidelines the MTUS Guidelines provide specific recommendations on the use of interferential stimulators. For these devices (pages 117-119) they state the following: Interferential stimulators are "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, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodological issues. In addition, although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support Interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. While not recommended as an isolated intervention, patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: - Pain is ineffectively controlled due to diminished effectiveness of medications. - Pain is ineffectively controlled with medications due to side effects. - History of substance abuse. - Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment. - 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. In this case, there is no evidence from review of the available medical records that the patient meets these above stated criteria for the use of an Interferential Stimulator. Specifically, there is insufficient information that the patient has undergone an adequate trial of NSAIDs, or that the patient was having significant side effects from NSAIDs, or that the patient failed to respond to conservative measures. Given these concerns, the use of an Interferential Stimulator (IF Rental Unit) is not considered as medically necessary.