

Case Number:	CM14-0185460		
Date Assigned:	11/13/2014	Date of Injury:	07/17/2002
Decision Date:	12/19/2014	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	11/07/2014

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 Internal Medicine, has a subspecialty in Hospice & Palliative Medicine and is licensed to practice in Pennsylvania. 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 gentleman with a date of injury of 07/17/2002. The submitted and reviewed documentation did not identify the mechanism of injury. Treating physician notes dated 06/25/2014 and 11/14/2014 indicated the worker was experiencing lower back pain that went into the left leg and pain in both knees. Documented examinations described tenderness in both knees and the lower back and positive testing with a straightened left leg. The submitted and reviewed documentation concluded the worker was suffering from lumbosacral sprain and strain with radiculopathy involving the left leg and right knee sprain. Treatment recommendations included pain medications, continued home exercise program, and follow up care. A Utilization Review decision was rendered on 10/31/2014 recommending non-certification for a replacement IF (interferential current stimulation) unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Replacement IF Unit: Upheld

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

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

Decision rationale: Interferential current stimulation is a type of electrical stimulation treatment for pain. The literature has not shown benefit from this treatment, possibly because of the limited quality studies available. The MTUS Guidelines support the use of this treatment only when it is paired with other treatments that are separately supported and in workers who have uncontrolled pain due to medications that no longer provide benefit, medications are causing intolerable side effects, a history of substance abuse limits the treatment options, the pain does not respond to conservative measures, and/or pain after surgery limits the worker's ability to participate in an active exercise program. A successful one-month trial is demonstrated by decreased pain intensity, improved function, and a decreased use of medication. The reviewed records indicated the worker was experiencing lower back pain that went into the left leg and pain in both knees. There was no documentation of any benefit from this treatment, suggestion that the worker met one of the above criteria, or discussion detailing the reason a new unit was needed. In the absence of such evidence, the current request for a replacement IF (interferential current stimulation) unit is not medically necessary.