

Case Number:	CM14-0020639		
Date Assigned:	04/30/2014	Date of Injury:	01/10/2008
Decision Date:	07/08/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	02/19/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 61-year-old male who reported an injury on 01/10/2008 secondary to an unknown mechanism of injury. The injured worker was evaluated on 01/13/2014 noting significant improvement in his right knee symptoms after right knee arthroplasty. The exam noted spasm and tenderness over the paravertebral muscles of the cervical spine, and some edema over the right knee. The treatment plan included a new home interferential unit for purchase. The notes indicated the unit is no longer functioning and the injured worker requires a new unit to allow him to reduce his intake of oral medications as well as increase his range of motion and functioning. Diagnoses include sprains and strains of the neck, enthesopathy of the knee, and olecranon bursitis. The Request for Authorization dated 01/31/2014 was in the documentation provided and the rationale was in the office notes provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME- INTERFERENTIAL UNIT FOR PURCHASE: 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: The California MTUS Guidelines do not recommend an interferential stimulator 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 on those recommended treatments alone. There is a significant lack of efficacy of the prior unit and the intended use in conjunction with other therapies. There is also a significant lack of clinically objective findings of the patient's pain level and functional deficits. Therefore, based on the documentation provided, the request is not medically necessary.