

Case Number:	CM14-0028091		
Date Assigned:	06/16/2014	Date of Injury:	11/20/2012
Decision Date:	08/12/2014	UR Denial Date:	01/31/2014
Priority:	Standard	Application Received:	03/05/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 57-year-old female who reported an injury on 11/20/2012. On 01/06/2014 the injured worker presented with pain in the brachial plexus region. She also reported 50% improvement in pain and increased activities due to scalene release therapy. Upon examination there was tenderness and guarding to the right paracervical area. There was also right scalene tenderness and positive axial head compression test to the right with decreased range of motion. There was also mild decreased range of motion to the right shoulder, and dysesthesia to the right C8-T1 dermatome. The diagnosis was post traumatic right thoracic outlet syndrome. Prior therapy included scalene release therapy with home exercise program. The provider recommended IF unit rental for 2 months with supplies. The provider's rationale was to help decrease pain throughout the brachial plexus region. The Request for Authorization form was dated 01/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME:IF UNIT RENTAL (2 MONTHS) WITH SUPPLIES: Upheld

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

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

Decision rationale: The request for a DME: IF unit rental (2 months) with supplies is not medically necessary. The California MTUS Guidelines do not recommend an IF 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. It may be recommended if pain is ineffectively controlled by medications, medication intolerance, history of substance abuse, significant pain from postoperative conditions which would limit the ability to perform exercise programs or physical therapy, or unresponsiveness to conservative measures. There is lack of evidence in the documentation provided that would reflect diminished effectiveness of medications, history of substance abuse, or postoperative conditions which would limit the injured workers ability to perform home exercise programs or physical therapy treatment. As such, the request is not medically necessary.