

Case Number:	CM14-0046922		
Date Assigned:	07/02/2014	Date of Injury:	08/08/2013
Decision Date:	08/08/2014	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/14/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 26-year-old man who sustained a work-related injury on August 8, 2013. Subsequently, he developed neck and back pain, and headaches. According to a progress report dated May 23, 2014, the patient reported on and off headaches, located about both sides of his head, characterized as a 7 to 8. He describes nausea, memory problems, depression, anxiety, and sleep difficulty. He complained of intermittent pain to the back of his neck, radiating to his shoulders. He reported constant bilateral shoulder pain and weakness. He indicated constant mid and low back pain associated with stiffness, spasms, and cramping, radiating to his right leg. He noted hip and thigh pain, associated with numbness, tingling, weakness, cramping, and spasms. Examination of the cervical spine revealed tenderness and spasms about the right trapezius. Range of motion of the cervical spine was restricted. Examination of the shoulders revealed tenderness of the right shoulder. Range of motion of the shoulders was restricted. Brief assessment of recent memory and immediate recall revealed some difficulty. Attention span appeared to be poor. Comprehension, repetition, and naming was normal. The patient emotionally appeared anxious and depressed. There was slight weakness of right shoulder abduction and flexion. The patient had normal finger-to-nose and heel-to-shin testing. Rapid alternating movements were normal bilaterally. Romberg was negative. The deep tendon reflexes were 1-2+ bilaterally. The patient had decreased sensation to pinprick about the right shoulder. The patient was diagnosed with lumbar spine sprain and strain, radiculopathy, and medial and lateral epicondylitis; with muscle contraction headaches and anxiety/depression. The patient was treated with acupuncture and medications (Norco, Anaprox, Robexin, and Butalbital). The provider requested authorization for the following procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential (IF) stimulator 1 month rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; Interferential Current Stimulation (ICS) Page(s): 120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: According to MTUS guidelines, Interferential Current Stimulation (ICS) is 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 methodology issues. While not recommended as an isolated intervention, the 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; or pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or significant pain from postoperative conditions limits the ability to perform exercise programs, and physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). There is no clear evidence that the patient did not respond to conservative therapies, or have post op pain that limit his ability to perform physical therapy. Therefore, the prescription of Interferential stimulator is not medically necessary.

Conductive garment: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Lumbar Traction: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308 - 309.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines <Low back Complaints Page(s): 308.

Decision rationale: According to MTUS guidelines, lumbar traction is not recommended as a physical treatment method for low back pain. Therefore, the prescription of lumbar traction is not medically necessary.

Supplies (Electrodes, Batteries, Wipes): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.