

Case Number:	CM14-0051998		
Date Assigned:	07/07/2014	Date of Injury:	05/09/2011
Decision Date:	08/12/2014	UR Denial Date:	03/21/2014
Priority:	Standard	Application Received:	04/18/2014

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 Occupational Medicine and is licensed to practice in Hawaii. 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:

This case is a 39 year-old male with a date of injury on 5/9/2011. A review of the medical records indicate that the patient is undergoing treatment for lumbar spine pain, right hip pain, right elbow pain, and right ankle pain. Subjective complaints (3/17/2014) include right knee pain and "no functional change since last visit". Objective findings (3/17/2014) include tenderness to right knee, right ankle, and right patella. Treatment has included Norco, Prilosec, Toprophan, Xanax, Trazadone, naproxen, and Sonata. Medical documents do not reveal that a 30 day trial of interferential unit treatment. A utilization review dated 3/21/2014 non-certified a request for DME: interferential unit due to lack of documented trial prior to purchase.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: INTERFERENTIAL UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 14-21.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): page(s) 54, 114-116, 118-120.

Decision rationale: ACOEM guidelines state "Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists." MTUS further states, "Not recommended as an isolated intervention." And details criteria for selection "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/ physical therapy treatment; or 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." The treating physician's progress notes do not indicate that the patient has poorly controlled pain, concerns for substance abuse, pain from postoperative conditions that limit ability to participate in exercise programs/treatments, or is unresponsive to conservative measures. Additionally, if the documentation supports the use of an interferential unit, the initial treatment step is to undergo a 30-day treatment trial. The medical documents do not indicate that a trial has occurred and the results of those trials. As such, current request for interferential unit is not medically necessary.