

Case Number:	CM14-0001228		
Date Assigned:	01/15/2014	Date of Injury:	03/23/2007
Decision Date:	01/31/2015	UR Denial Date:	12/16/2013
Priority:	Standard	Application Received:	01/03/2014

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 Rehab, has a subspecialty in Interventional spine, and is licensed to practice in California. 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 57-year-old female with a date of injury of 03/23/2007. The most recent progress report provided for review is dated 11/13/2014. According to this report, the patient has sleep issues and pain level rated as 7/10. There is a decrease in range of motion in the lumbar spine. All other subjective and objective findings are illegible. Recommendation was for refill of Ambien and Soma. According to report dated 10/07/2014, recommendation was made for pain management followup with [REDACTED]. The patient reported no new symptoms. She does state that she has continued anxiety and depression which are manageable. Report 08/21/2014 notes the patient continues with low back pain which is rated as 6/10, and Ambien helps with sleeping. Soma and Ambien were refilled. Report 08/12/2014 notes the patient has left shoulder and low back pain with no new symptoms. The listed diagnoses are: 1. Status post left shoulder surgery 07/30/2007. 2. Lumbar spine disk rupture. 3. Other problems unrelated to current evaluation. This is a request for IF unit with supplies. The medical reports provided for review provide no discussion regarding this request. The utilization review denied the request for the IF unit on 12/16/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF unit with supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: This patient presents with shoulder and low back complaints. The current request is for IF unit with supplies. For Interferential Current Stimulation (ICS), the MTUS guidelines, pages 118 - 120, state that "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." These devices are recommended in cases where (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or (4) Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (5) Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). The rationale for the request was not provided in the medical file provided for review. In this case, there is no documentation of substance abuse, operative condition, or unresponsiveness to conservative measures. Furthermore, MTUS requires a 30-day trial of the unit showing pain and functional benefit before a home unit is allowed. Given that the request is for an IF unit without a specific request for one-month trial, recommendation cannot be made. The request for IF unit with supplies is not medically necessary.