

Case Number:	CM14-0186447		
Date Assigned:	11/14/2014	Date of Injury:	10/30/2007
Decision Date:	01/05/2015	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	11/10/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 patient is a 50 year old female employee with date of injury of 10/30/2007. A review of the medical records indicate that the patient is undergoing treatment for neck sprain, displacement of intervertebral disc without myelopathy, spinal stenosis in cervical region, sprain of thoracic, sprain of lumbar and carpal tunnel syndrome. Subjective complaints include neck and left arm pain, the same since a previous exam. Symptoms described as moderate and severe. Pain described as constant, sharp, burning, numbness, aching, soreness, and weakness. Pain rated at 6/10 with medications, 8-9/10 without medications. Objective findings include exam of cervical spine revealing tenderness to palpation and spasm in the upper trapezius left greater than right. An exam of the thoracic and lumbar regions revealed tenderness to palpation over the paravertebral muscles and spasm. Treatment has included home exercises and an EMS unit. Medications have included Norco, Cyclobenzaprine and Gabapentin which have been effective in reducing pain. The utilization review dated 10/31/2014 non-certified the request for 2 Months rental of IF Unit with Supplies.

IMR ISSUES, DECISIONS AND RATIONALES

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

2 Months rental of IF Unit with Supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ICS Page(s): 120.

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): 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 regarding interferential units, "Not recommended as an isolated intervention" and details the 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 does not document functional improvement with the previous IF rental unit nor do the files indicate compliance with the previous unit or how long the unit has been used. Without these objective measurements, the request for two months rental of Inferential Unit with Supplies not medically necessary.