

Case Number:	CM14-0189361		
Date Assigned:	11/20/2014	Date of Injury:	04/13/2013
Decision Date:	01/21/2015	UR Denial Date:	11/06/2014
Priority:	Standard	Application Received:	11/13/2014

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, 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:

According to the records made available for review, this is a 63-year-old female with a 4/13/13 date of injury. At the time (11/6/14) of request for authorization for Interferential stimulator unit, there is documentation of subjective (increased right shoulder pain with lifting, pushing, pulling reaching, and loading) and objective (right shoulder tenderness, positive impingement; lumbar spine increased lordosis, tenderness, paravertebral muscles spasms, limited range of motion, and increased low back pain with bilateral straight leg raise) findings, current diagnoses (right shoulder strain, lumbar spine sprain/strain, facet hypertrophy, cervical spine sprain/strain, bilateral upper extremity radiculopathy, left hip greater trochanteric bursitis), and treatment to date (epidural steroid injection, activity modification, medications, physical therapy, acupuncture, chiropractic, and right shoulder injection). There is no documentation that the IF unit will be used in conjunction with additional recommended treatments, including return to work.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential stimulator unit: Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that interferential current stimulation is not recommended as an isolated intervention and that 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. Within the medical information available for review, there is documentation of diagnoses of right shoulder strain, lumbar spine sprain/strain, facet hypertrophy, cervical spine sprain/strain, bilateral upper extremity radiculopathy, left hip greater trochanteric bursitis. In addition, there is documentation that the IF unit will be used in conjunction with recommended treatments, including exercise and medications, and limited evidence of improvement on those recommended treatments alone. However, there is no documentation that the IF unit will be used in conjunction with additional recommended treatments, including return to work. Therefore, based on guidelines and a review of the evidence, the request for Interferential stimulator unit is not medically necessary.