

Case Number:	CM14-0045948		
Date Assigned:	07/02/2014	Date of Injury:	10/12/2013
Decision Date:	09/29/2015	UR Denial Date:	04/03/2014
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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 injured worker is a 52 year old female, who sustained an industrial injury on 10-12-2013. She has reported injury to the neck, left shoulder, and low back. The diagnoses have included cervical sprain; lumbar sprain; left shoulder sprain-strain; left shoulder full thickness tear supraspinatus tendon, impingement syndrome; and right third trigger finger. Treatments have included medications, diagnostics, cold-hot pack, and lumbar support. Medications have included Ibuprofen, Naproxen, Flexeril, and Therma-Care. A medical necessity addendum from the treating physician, dated 03-14-2014, documented the need for an interferential stimulator for the injured worker. Currently, the injured worker complains of pain and muscle spasms in the neck and back; and the pain limits the ability to perform exercise-physical therapy treatment. Objective findings have included exhibiting restricted motion. The treatment plan has included the request for interferential stimulator (four month rental) (neck and back).

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential stimulator (four month rental) (neck and back): Upheld

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

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

Decision rationale: The patient was injured on 10/12/13 and presents with neck and back pain. The request is for an interferential stimulator (four month rental) (neck and back). The RFA is dated 03/14/14 and the patient is on "regular" work status. MTUS Guidelines, Interferential Current Stimulation (ICS), 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 patient has muscle spasms in the neck and back, a restricted range of motion and pain limits the ability to perform exercise-physical therapy treatment. She is diagnosed with cervical sprain, lumbar sprain, left shoulder sprain-strain, left shoulder full thickness tear supraspinatus tendon, impingement syndrome, and right third trigger finger. Treatment to date includes medications, diagnostics, cold-hot pack, and lumbar support. Review of progress reports does not show documentation of patient's history of substance abuse, operative condition, nor unresponsiveness to conservative measures. Documentation to support MTUS criteria has not been met. Furthermore, MTUS require 30-day trial of the unit showing pain and functional benefit before a home unit is allowed. In this case, there was no 30 day trial with the interferential unit and the request is for a 4 month trial. Therefore, the requested IF stimulator is not medically necessary.