MAXIMUS Federal Services

Case Number:	CM15-0006170		
Date Assigned:	01/29/2015	Date of Injury:	01/07/2014
Decision Date:	03/18/2015	UR Denial Date:	12/15/2014
Priority:	Standard	Application Received:	01/12/2015

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: New Jersey, Michigan, California
Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 53 year old female, who sustained an industrial injury on January 7, 2014. The diagnoses have included headache, cervical sprain/strain, cervical muscle spasm, cervical disc protrusion per the nerve root compromise, rule out cervical radiculitis versus radiculopathy, cervical spondylosis, thoracic sprain/strain, thoracic muscle spasm, thoracic spondylosis, lumbosacral sprain/strain, lumbar muscle spasm, lumbar disc protrusion with bilateral nerve root compromise and degeneration of the spine, left shoulder sprain/strain, left shoulder muscle spasm, right shoulder sprain/strain, righter should muscle spasm, left knee sprain/strain, left knee medial meniscus tear, loss of sleep, psych component and status post-surgery left knee. Treatment to date has included Magnetic resonance imaging cervical, lumbar and left knee. Currently, the injured worker complains of occasional moderate headache, stabbing neck pain and tingling, sharp upper/mid back pain and numbness, sharp low back pain and numbness and right and left shoulder pain with tingling. On December 15, 2014 Utilization Review non-certified a home exercise IF 4000 unit, noting, Medical Treatment Utilization Schedule Guidelines was cited. On December 9, 2014, the injured worker submitted an application for IMR for review of home exercise IF 4000 unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Exercise IF 4000 Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46-47, 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, page(s) 118-119>. Page(s): 118-119.

Decision rationale: According to MTUS guidelines, < Interferential Current Stimulation (ICS). 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. (Van der Heijden, 1999)(Werner, 1999) (Hurley, 2001) (Hou, 2002) (Jarit, 2003) (Hurley, 2004) (CTAF, 2005)(Burch, 2008) The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine:- 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.).>There is no clear evidence that the patient did not respond to conservative therapies, or have post op pain that limit his ability to perform physical therapy. There is no clear evidence that the neurostimulator will be used will as a part of a rehabilitation program. In Addition, there is a limited evidence supporting the use of neuromuscular stimulator for chronic pain. Therefore, Home Exercise IF 4000 Unit is not medically necessary.