

Case Number:	CM15-0007916		
Date Assigned:	01/23/2015	Date of Injury:	02/19/2014
Decision Date:	03/17/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	01/14/2015

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 61 year old female, who sustained an industrial injury on 2/19/14. The injured worker complains of chronic left knee, low back and right wrist pain. She has tenderness of the medial joint line in the left knee, crepitus, positive grind test, decreased range of motion, decreased muscle strength in the lower extremity, ambulation with a limp favoring the left lower extremity, tenderness of the right wrist, positive right wrist orthopedic testing and decreased sensation in the medial nerve distribution. The diagnoses have included status post left knee arthroscopy; lumbar spine musculoligamentous sprain/strain with left sacroiliac joint sprain; right elbow strain, medial and lateral epicondylitis, possible cubital tunnel syndrome and right forearm/wrist strain with possible carpal tunnel syndrome. Treatment to date has included left knee arthroscopy, exercise and electrical muscle stimulation, brace, acupuncture, ultrasound, electromyogram/NCV and medications. According to the utilization review performed on 12/17/14, the requested IF unit has been non-certified and requested 1 Office visit follow up has been certified. ODG and CA Chronic Pain Medical Treatment Guidelines were used.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation 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 her ability to perform physical therapy. There is no clear evidence that the neurostimulator will be used as a part of a rehabilitation program. . Therefore, the request for Interferential unit is not medically necessary.