

Case Number:	CM15-0100223		
Date Assigned:	06/03/2015	Date of Injury:	04/23/2013
Decision Date:	07/08/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	05/27/2015

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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 41-year-old female injured worker suffered an industrial injury on 04/23/2013. The diagnoses included cervical strain/sprain with degenerative disc disease with brachial myofascial pain syndrome, left shoulder strain with impingement syndrome, left carpal tunnel syndrome, lumbar strain with degenerative disc disease with radiculopathy, left sacroiliac joint dysfunction and chronic pain syndrome. The diagnostics included left shoulder x-rays and neck, back and left shoulder magnetic resonance imaging. The injured worker had been treated with medications, physical therapy, chiropractic therapy, injections, electrical stimulator, massage, splinting/bracing and psychotherapy. On 4/27/2015, the treating provider reported pain in the neck, back, shoulders, left arm and left leg. The constant pain was rated 6 to 9/10. The treatment plan included Interferential Stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 purchase or rental of Interferential Stimulator unit: Upheld

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

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

Decision rationale: The MTUS Guidelines do not recommend an interferential stimulator as an isolated treatment, however it may be useful for a subset of individuals that have not had success with pain medications. The evidence that an interferential stimulator is effective is not well supported in the literature, and studies that show benefit from use of the interferential stimulator are not well designed to clearly demonstrate cause and effect. The guidelines support the use of an interferential stimulator for a one-month trial to determine if this treatment modality leads to increased functional improvement, less reported pain and medication reduction. The request is not for a one-month trial however, and the unit is not recommended for use without the trial and document evidence of benefit. The request for 1 purchase or rental of Interferential Stimulator unit is determined to not be medically necessary.