MAXIMUS Federal Services

Case Number:	CM15-0108735		
Date Assigned:	06/15/2015	Date of Injury:	08/02/2013
Decision Date:	07/14/2015	UR Denial Date:	05/18/2015
Priority:	Standard	Application Received:	06/05/2015

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: Family Practice

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 48 year old male, who sustained an industrial injury on 8/2/13. He reported gradual onset of pain in knees, back, hernia, left ankle, right hand and headaches. The injured worker was diagnosed as having lumbar spine sprain, cervical spine strain, left and right knee sprain/strain internal derangement status post arthroscopy, left and right ankle sprain/strain, and cephalgia and sleep disorder. Treatment to date has included topical medications including Lido/Keto cream, Flurbiprofen/Capsaicin/Menthol/Camphor cream and Lidoderm patches, oral medications including Anaprox, Fexmid, Tramadol and Prilosec and activity restrictions. Currently, the injured worker complains of pain in neck with radiation to right and left arm, pain lower back with radiation to right and left leg, pain in right and left knee and pain in right and left foot/ankle restricted range of motion with tenderness to Achilles tendon attachment to the calcaneus and medial and lateral joint line tenderness. He is temporarily totally disabled. Physical exam noted restricted cervical range of motion with tightness and spasm of trapezius, sternocleidomastoid and straps muscle; restricted lumbar range of motion with tightness and spasm in the lumbar paraspinal musculature bilaterally with hypoesthesia, restricted right and left knee range of motion with chondromalacia patellar compression test positive. Requests for authorization were submitted for follow up appointment, (EMG) Electromyogram/(NCV) Nerve Condition Velocity studies of bilateral lower extremities, (MRI) magnetic resonance imaging of lumbar spine and bilateral ankles, ultrasound guided injections to both knees and ankles, physical therapy for lumbar spine and both legs, neurology evaluation and a cane for support.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective IF(Interferential) unit with supplies 5 month rental: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Therapy Page(s): 117-120.

Decision rationale: The MTUS/Chronic Pain Medical Treatment guidelines comment on the use of an Interferential (IF) Unit as a treatment modality. These guidelines state that an IF unit is 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. While not recommended as an isolated intervention, the following are 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.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A jacket should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. In this case the medical records do not provide sufficient information to assess whether the patient meets the above cited MTUS criteria for the use of an IF unit. Further, the request was for a 5-month rental. The MTUS guidelines clearly state that a one-month trial may be appropriate. Given the lack of documentation in support of a rationale to use an IF unit and that the request exceeded the one-month trial, the use of an IF unit with supplies for a 5 month rental was not medically necessary.