

Case Number:	CM15-0131629		
Date Assigned:	07/17/2015	Date of Injury:	04/23/2013
Decision Date:	08/13/2015	UR Denial Date:	06/08/2015
Priority:	Standard	Application Received:	07/07/2015

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: Connecticut, California, Virginia
 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 injured worker is a 41 year old female, who sustained an industrial injury on 04/23/2013. She has reported injury to the neck, left shoulder, and low back. The diagnoses have included cervical strain/sprain and myofascial pain; cervical degenerative disc disease; cervical brachial myofascial pain syndrome; left shoulder strain with development of impingement syndrome and rotator cuff tendinitis; left wrist strain/sprain; left carpal tunnel syndrome; lumbar strain/sprain and myofascial pain; lumbar degenerative disc disease and left lumbosacral radiculopathy; left sacroiliac joint dysfunction associated with pelvic obliquity; and chronic pain syndrome. Treatment to date has included medications, diagnostics, injections, chiropractic therapy, physical therapy, and home exercise program. Medications have included Ultram, Relafen, Pamelor, Terocin Patches, and Prilosec. A progress report from the treating physician, dated 05/28/2015, documented a follow-up visit with the injured worker. Currently, the injured worker reported pain in the neck, back, and left shoulder, currently rated at 5/10 on the visual analog scale; average pain is rated 5/10 on the visual analog scale; the pain is described as achy, tingling, shooting, throbbing, burning, radiating, numbing, and deep; and the pain is constant and helped by medications. Objective findings included decreased, painful range of motion of the neck and shoulders, worse on the left, and the low back. The treatment plan has included the request for purchase or rental of electrical stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase or rental of Electrical Simulator: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines interferential current stimulator Page(s): 118-120.

Decision rationale: The MTUS guidelines do not recommend interferential current stimulation (ICS) as an isolated intervention. There are no standardized protocols for the use of interferential therapy, and the evidence does not support clear value to treatment, and while not recommended as an isolated intervention, patients should be selected for consideration only by meeting the following criteria: pain ineffectively controlled due to diminished effectiveness of medications or pain is ineffectively controlled with medications due to side effects. Additional criteria may include history of substance abuse or significant pain from postoperative conditions limiting the ability to perform exercise programs/physical therapy treatment, or unresponsiveness to conservative measures (repositioning, heat/ice, etc.). If the aforementioned criteria are met, consideration of a one-month trial may be appropriate to assess added benefit of treatment. The provided records do not discuss the criteria that would support consideration of ICS therapy, and therefore given the provided records, the request cannot be considered medically necessary. Should the criteria be discussed and met, reconsideration may be warranted.