

Case Number:	CM15-0134428		
Date Assigned:	07/17/2015	Date of Injury:	01/07/2011
Decision Date:	08/14/2015	UR Denial Date:	06/25/2015
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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 male, who sustained an industrial injury on 1/7/2011. Diagnoses have included chronic low back pain, chronic left shoulder pain and left hip pain, left wrist injury and neurological deficit bilateral lower extremities. Treatment to date has included magnetic resonance imaging (MRI) and medication. According to the progress report dated 5/22/2015, the injured worker complained of left shoulder and left hip pain. He also complained of right knee pain. He was taking Norco and Ibuprofen. It was noted that physical therapy had been authorized but had not started yet. The injured worker had an antalgic gait. Exam of the lumbar spine revealed tenderness to palpation. He had muscle atrophy in both legs and hands. Exam of the left shoulder revealed tenderness to palpation. There was tenderness to palpation of the left hip. Authorization was requested for an interferential unit for the left hip and lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential (IF) unit (left hip and lumbar spine): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential stimulator unit Page(s): 118.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Regarding the request for interferential unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is indication that the patient's pain medications cause GI upset, although this does apparently respond to treatment with a proton pump inhibitor. Regardless, there is no documentation of an IF unit trial and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested interferential unit is not medically necessary.