

Case Number:	CM15-0160869		
Date Assigned:	08/27/2015	Date of Injury:	01/24/2000
Decision Date:	09/30/2015	UR Denial Date:	07/22/2015
Priority:	Standard	Application Received:	08/17/2015

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

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 52 year old male, who sustained an industrial injury on 01-24-2000. On provider visit dated 07-01-2015 the injured worker has reported neck pain, low back pain, lower extremity pain, bilaterally knees pain and frequent muscles spasms in back. On examination the cervical spine was noted to have spasms in the paraspinous muscles bilaterally and vertebral tenderness was noted in the cervical spine C5-C7 and pain was noted with flexion and extension. Lumbar spine was noted as having spasms in the bilateral paraspinous muscles. Tenderness was noted as well in the bilateral paravertebral areas. Pain was noted to increase with flexion and extension. Straight leg raise was noted to positive bilaterally. The diagnoses have included chronic pain and status post knee surgery and lumbar radiculopathy. The left knee was noted to have tenderness to left knee and range of motion was decreased due to pain. Treatment to date has included lumbar injection, medication and physical therapy. The provider requested IF Unit and Supplies (batteries and electrodes).

IMR ISSUES, DECISIONS AND RATIONALES

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

IF Unit and Supplies (batteries and electrodes): 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): 118-120.

Decision rationale: The patient presents with neck pain radiating to the bilateral upper extremities, low back pain radiating to the bilateral lower extremities, and bilateral knee pain. The request is for IF UNIT AND SUPPLIES (BATTERIES AND ELECTRODES). Patient is status post right knee surgery, 09/02/14. Physical examination to the cervical spine on 04/10/15 revealed tenderness to palpation to the paravertebral muscles bilaterally with spasm. Range of motion was restricted with pain. Examination to the lumbar spine revealed tenderness to palpation to the paravertebral muscles bilaterally with spasm. Range of motion was restricted with pain. Per 03/27/15 progress report, patient's diagnosis includes discogenic pain, L5-S1; 5mm disc protrusion. L5-S1; Retrolisthesis, L5-S1. Patient's medications, per 07/01/15 progress report include Diclofenac, Gabapentin, Hydrocodone, Ibuprofen, Norflex and Pantaprazole. Patient is not working. For Interferential Current Stimulation (ICS), MTUS guidelines, pages 118-120, state that 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. These devices are recommended in cases where (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or (4) Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (5) Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). Treater has not discussed this request and no RFA was available either. The utilization review dated 07/22/15 has modified the request to 1 month use of IF unit and supplies (batteries and electrodes) between 07/09/15 and 09/13/15. In this case, there is no evidence that medications and conservative care are ineffective or that the patient has a history of substance abuse. The treater does not document side effects due to medication. Given the lack of any discussion regarding the request, the indication for the use of this unit cannot be determined. The request IS NOT medically necessary.