

Case Number:	CM15-0021933		
Date Assigned:	02/11/2015	Date of Injury:	10/08/2014
Decision Date:	03/31/2015	UR Denial Date:	01/19/2015
Priority:	Standard	Application Received:	02/05/2015

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, Hawaii

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 46 year old female, who sustained an industrial injury on 10/8/2014. The diagnoses have included cervical spine sprain/strain, lumbar spine sprain/strain, lumbar radiculitis and left elbow sprain/strain. Treatment to date has included chiropractic manipulation, acupuncture and pain medications. According to the progress note dated 12/12/2014, the injured worker was seen for re-evaluation of her upper back, low back, bilateral wrists and hands and she had problems with her eyes. She reported that her neck pain was pretty constant. She complained of numbness and tingling radiating down into the elbows and hands. Physical exam revealed decreased range of motion with tenderness over the paraspinous muscles of C5-C6 and C6-C7 bilaterally with muscle spasms noted. She had tenderness over the left elbow and decreased range of motion. She had decreased range of motion with tenderness over the hands and wrists bilaterally. A urine toxicology screen from 11/4/2014 was noted to be consistent. X-rays of the cervical spine from 12/6/2014 showed straightening of the cervical spine suggestive of lordosis. Authorization was requested for a Transcutaneous Electrical Nerve Stimulation (TENS) unit. On 1/9/2015, Utilization Review (UR) non-certified a request for an Interferential Muscle Stimulator unit with supplies. The Medical Treatment Utilization Schedule (MTUS), American College of Occupational and Environmental Medicine (ACOEM) Guidelines and Official Disability Guidelines (ODG) were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential muscle stimulator: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): (p118-120).

Decision rationale: The patient presents with cervical spine sprain/strain, lumbar spine sprain/strain, lumbar radiculitis, and left elbow sprain/strain. The current request is for Interferential muscle stimulator. The treating physician states, on an order form faxed to Orthromed, a Certificate of Medical Necessity for an I.F. Unit supplies as needed and Purchase in a report dated 12/12/14 (39). The MTUS guidelines state: Not recommended as an isolated intervention. 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. In this case, the treating physician, based on the records available for review, has failed to document any of the conditions listed above, and has failed to justify the purchase of an IF instead of a one-month trial, had the above conditions been met. The current request is not medically necessary and the recommendation is for denial.