Case Number:	CM15-0027457		
Date Assigned:	02/19/2015	Date of Injury:	12/03/1998
Decision Date:	03/31/2015	UR Denial Date:	02/03/2015
Priority:	Standard	Application Received:	02/13/2015

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: Maryland
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 40 year old female who sustained an industrial injury on 12/3/1998. Current diagnoses include sprain/strain of sacroiliac joint, sprain/strain hip/thigh, cubital tunnel syndrome, impingement syndrome, causalgia upper, sprain/strain cervical, and carpal tunnel syndrome. Previous treatments included medication management and left shoulder surgery. Report dated 01/28/2015 noted that the injured worker presented with complaints that included left hip, right shoulder, neck, left elbow, left shoulder, and right hand pain. Physical examination was positive for abnormal findings. Utilization review performed on 02/03/2015 non-certified a prescription for interferential unit x 1 for purchase, based on the clinical information submitted does not support medical necessity. The reviewer referenced the California MTUS in making this decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF unit x1 purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120, 69, 88.

MAXIMUS guideline: 9792.20. Medical Treatment Utilization Schedule: Definitions (f) page 1

Decision rationale: IF unit x1 purchase is interferential treatment 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. The guidelines state that despite this lack of effectiveness the IF unit can possibly be 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 the patient is 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. The documentation does not indicate evidence of significant functional improvement as defined by the MTUS or evidence of sustained medication reduction using the IF unit. The request for an IF unit purchase is not medically necessary.