

Case Number:	CM15-0212853		
Date Assigned:	11/02/2015	Date of Injury:	07/11/2007
Decision Date:	12/18/2015	UR Denial Date:	09/30/2015
Priority:	Standard	Application Received:	10/28/2015

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: Florida

Certification(s)/Specialty: Family Practice

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 59-year-old female who sustained an industrial injury 07-11-07. A review of the medical records reveals the injured worker is undergoing treatment for L4-5 disc injury with right lumbar radiculopathy and facet arthropathy. Medical records (06-08-15) reveal the injured worker complains of back pain, right leg pain and swelling, and loss of balance. The physical exam (06-08-15) reveals decreased thoracolumbar spine range of motion, with no pain or spasm noted on the date of exam. Prior treatment includes medications including naproxen, cyclobenzaprine, Napro and Mentherm creams, Tramadol, Tizanidine, Motrin, Vicodin, Diclofenac, fluoxetine, Ambien, omeprazole, Protonix, Amitriptyline, Lidoderm patches, and gabapentin, as well as acupuncture treatments, chiropractic treatments, sacroiliac injections, several injections of Toradol and B12, epidural steroid injections, lumbar facet injections, a lumbar brace, home exercise program, aquatic and physical therapy. The original utilization review (09-30-15) non certified the request for an interferential stimulator with supplies and setup with a 1 month rental. There is not discussion in the medical records available for review of the requested interferential unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential stimulator unit, tech fit with instruction, supplies (electrodes packs #4, power packs #12, adhesive remover towel mint #16 and lead wire #1), shipping and handling for 1 month rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: Interferential Current Stimulation (ICS) MTUS, pg 127. 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. While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: 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. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. Regarding this patient's case, MTUS criteria have not been satisfied. There is lack of documentation that this patient has failed all possible conservative treatment measures. IF units are not recommended as isolated interventions. Likewise, this request is not considered medically necessary.