

Case Number:	CM15-0213900		
Date Assigned:	11/03/2015	Date of Injury:	10/03/2013
Decision Date:	12/22/2015	UR Denial Date:	10/08/2015
Priority:	Standard	Application Received:	10/30/2015

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 31 year old female who sustained an industrial injury October 3, 2013. Diagnosis is documented as dysthymic disorder. According to a treating physician's progress report dated October 2, 2015, the injured worker presented with overall pain, rated 8 out of 10. She reports headaches, numbness and tingling, right posterior hand, upper thoracic, cervical, right cervical dorsal, right posterior elbow, left cervical dorsal, and right and left sacroiliac pain, which is present 100% of the time. The physician documented that the injured worker experiences dizziness, anxiety, stress and insomnia, and a feeling of suicidal thoughts (unspecified) but feels better with pain medication. Objective findings included; palpable cervical, thoracic, sacroiliac, sacral buttocks, left and right leg and left and right knee tenderness. Treatment plan included a consultation with neurology regarding headaches a cervical and lumbar MRI, medications; Norco, topical compound, Prilosec, Lidoderm patches, and Voltaren gel and at issue a request for authorization dated October 2, 2015, for a home interferential unit (1 month rental). An MRI of the cervical spine dated September 4, 2015 (report present in the medical record) impression; a 1.5mm central-paracentral disc protrusion at C5-6; straightening of the cervical curvature; no central spinal canal stenosis; no cervical cord abnormality. According to utilization review dated October 8, 2015, the request for a Home Interferential Stimulator Unit (1 month rental) is non -certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Interferential Unit (1 month rental): Overturned

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: The patient presents with headache, right TMJ, left TMJ, right clavicular, left clavicular, right hip, left hip, right anterior leg, left anterior leg, right anterior knee, left anterior knee, right ankle, left ankle, headache, left cervical, cervical, right cervical dorsal, right cervical, upper thoracic, left cervical dorsal, left mid thoracic, mid thoracic, lower thoracic, left lumbar, lumbar, left sacroiliac, right sacroiliac, right pelvic, right buttock, sacral, left buttock, left pelvic, left posterior leg, right posterior leg, left ankle, left posterior elbow and right posterior elbow pain. The current request is for Home Interferential Unit (1 month rental). The treating physician's report dated 10/02/2015 (55B) states, "In accordance with MTUS, ACOEM and ODG guidelines, I am requesting authorization for a 1 month rental of a home interferential unit for pain control. A trial period of treatment with the unit will enable evaluation of another tool for improved function and a reduction of symptoms." The MTUS guidelines page 111 to 120 on IF Units states that interferential current stimulation 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. In addition, a one-month trial may be appropriate to permit the treater to study the effects and benefits of its use. Medical records show that the patient has not trialed the IF unit. In this case, the MTUS Guidelines support a 1-month trial of this modality to determine its efficacy in terms of pain relief and functional improvement. The current request is medically necessary.