

Case Number:	CM15-0042092		
Date Assigned:	03/12/2015	Date of Injury:	03/05/2012
Decision Date:	05/01/2015	UR Denial Date:	02/11/2015
Priority:	Standard	Application Received:	03/05/2015

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: District of Columbia, Virginia
 Certification(s)/Specialty: Internal 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 64-year-old male, who sustained an industrial injury on 3/5/2012. The current diagnosis is severe left wrist carpometacarpal joint osteoarthritis. According to the progress report dated 1/21/2015, the injured worker complains of pain in the bilateral wrists, shoulders, knees, and right elbow. The pain is rated 3/10 on a subjective pain scale. The current medication list was not available for review. Treatment to date has included bilateral wrist braces and physical therapy. The plan of care includes 12 additional physical therapy sessions to the left wrist and interferential unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for left wrist, three times a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792 Page(s): 98-99.

Decision rationale: Per MTUS: Physical Medicine Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine Guideline allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. Per review of the clinical documentation provided, there is no evidence that the patient had functional improvement with prior PT sessions. Additional PT sessions would not be indicated, and therefore is not medically necessary.

Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792 Page(s): 118-120.

Decision rationale: Per MTUS: Interferential Current Stimulation (ICS) 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 randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. (Van der Heijden, 1999) (Werner, 1999) (Hurley, 2001) (Hou, 2002) (Jarit, 2003) (Hurley, 2004) (CTAF, 2005) (Burch, 2008) The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. In addition, although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support Inferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. Two recent

randomized double-blind controlled trials suggested that ICS and horizontal therapy (HT) were effective in alleviating pain and disability in patients with chronic low back pain compared to placebo at 14 weeks, but not at 2 weeks. The placebo effect was remarkable at the beginning of the treatment but it tended to vanish within a couple of weeks. The studies suggested that their main limitation was the heterogeneity of the low back pain subjects, with the interventions performing much better for back pain due to previous multiple vertebral osteoporotic fractures, and further studies are necessary to determine effectiveness in low back pain from other causes. (Zambito, 2006) (Zambito, 2007) A recent industry-sponsored study in the Knee Chapter concluded that interferential current therapy plus patterned muscle stimulation (using the RS-4i Stimulator) has the potential to be a more effective treatment modality than conventional low-current TENS for osteoarthritis of the knee. (Burch, 2008) This recent RCT found that either electro-acupuncture or interferential electrotherapy, in combination with shoulder exercises, is equally effective in treating frozen shoulder patients. It should be noted that this study only showed the combined treatment effects with exercise as compared to no treatment, so the entire positive effect could have been due to the use of exercise alone. (Cheing, 2008) See also Sympathetic therapy. See also TENS, chronic pain.

How it works: Paired electrodes of two independent circuits carry differing medium frequency alternating currents so that current flowing between each pair intersects at the underlying target. The frequency allows the Interferential wave to meet low impedance when crossing the skin. Treatments involve the use of two pairs of electrodes and most units allow variation in waveform, stimulus frequency and amplitude or intensity, and the currents rise and fall at different frequencies. It is theorized that the low frequency of the interferential current causes inhibition or habituation of the nervous system, which results in muscle relaxation, suppression of pain and acceleration of healing. How it is different than TENS: It has been postulated that Interferential stimulation allows for deeper penetration of tissue, whereas TENS is predominantly a cutaneous or superficial stimulus. Interferential current is proposed to produce less impedance in the tissue and the intensity provided is suggested to be perceived as more comfortable. Because there is minimal skin resistance with the interferential current therapy, a maximum amount of energy goes deeper into the tissue. It also crisscrosses, as opposed to the linear application of the TENS. This crisscrossing is postulated to be more effective because it serves to confuse the nerve endings, preventing the treated area from adjusting to the current. There are no published randomized trials comparing TENS to Interferential current stimulation. 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. Per review of the cited guidelines, and review of the clinical documentation provided, there is no evidence that patient was to receive an IF unit as part of therapy. IF units are not recommended as isolated therapy, as per guidelines, and would not be recommended, and therefore is not medically necessary.