

Case Number:	CM15-0051678		
Date Assigned:	03/25/2015	Date of Injury:	02/21/2012
Decision Date:	05/01/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/18/2015

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: Pennsylvania
 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 44 year-old female who has reported low back and shoulder pain after an injury on February 21, 2012. The diagnoses include lumbar annular disc tears, left lumbar radiculitis, left piriformis syndrome, and bilateral shoulder adhesive capsulitis. Treatment to date has included physical therapy and medications. The treating physician reports during 2014 to 2015 reflect ongoing low back pain, shoulder pain, and stiffness. A variety of medications are listed. The work status on each report is temporarily totally disabled on a psychological basis. None of the reports discuss the use, indication, or results for an interferential (IF) stimulation unit. On October 24, 2014, there was ongoing low back and shoulder pain. Shoulder range of motion was limited. Medications were listed. The treatment plan included a three-month trial of transcutaneous electrical nerve stimulation (TENS)/inferential stimulating unit to help control low back pain in attempts to decrease oral medications. There was no further discussion of this modality and subsequent reports do not mention it. The actual prescription for this device is for an interferential stimulation unit, for 3 months use. On 2/24/15 Utilization Review non-certified an interferential stimulation unit and associated supplies. The MTUS was cited, and the lack of specific indications and a proper trial were noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective durable medical equipment (DME) interferential stimulator, 1 month rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120. Decision based on Non-MTUS Citation ACOEM Guidelines, Chronic Pain Update 8/14/08, Page 189, IF stimulation and update, 4/7/08, Low Back, page 166, IF stimulation.

Decision rationale: The ACOEM guidelines, 2004 version and the updated chapters cited above, do not recommend interferential therapy for any pain or injury conditions. The MTUS for Chronic Pain provides very limited support for interferential treatment, notes the poor quality of medical evidence in support of interferential stimulation therapy, and states that there is insufficient evidence for using interferential stimulation for wound healing or soft tissue injury. The treating physician has not provided a treatment plan which includes interferential stimulation therapy in the context of the recommendations of the MTUS. This includes return to work, exercise, medications, and no conductive garment. The temporarily totally disabled work status is evidence of a treatment plan not sufficiently focused on improving function. There is no evidence of any benefit from the interferential stimulation unit that was apparently dispensed around October, 2014, as none of the subsequent reports mention it and there is no clinical evidence of improvement in any of these reports. The interferential unit is not medically necessary based on lack of medical evidence, guidelines, and a treatment plan not in accordance with guidelines.

Retrospective durable medical equipment (DME) electrodes, 4 packs: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Retrospective durable medical equipment (DME) adhesive remover towel mint #16: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Retrospective durable medical equipment (DME) power packs #12: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.