MAXIMUS Federal Services

Case Number:	CM15-0051981		
Date Assigned:	03/25/2015	Date of Injury:	05/09/2007
Decision Date:	05/01/2015	UR Denial Date:	03/11/2015
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: 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 43 year old female, who sustained an industrial injury on 5/9/2007. She reported a slip and fall, landing in the sitting position. The injured worker was diagnosed as having coccydynia, lumbar degenerative disc disease and lumbar radiculopathy. There is no record of a recent magnetic resonance imaging. Treatment to date has included physical therapy, acupuncture, injections and medication management. Currently, the injured worker complains of tailbone and lower back pain. In a progress note dated 2/23/2015, the treating physician is requesting interferential stimulator with electrodes, wires and batteries for coccyx pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Stimulator with electrodes, wires, batteries: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Device Page(s): 127.

Decision rationale: MTUS guidelines state regarding Interferential Current Stimulation Devices, "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." MTUS guidelines go on to state that while an IF unit is not recommended as an isolated intervention, patient selection criteria should be applied if Interferential stimulation is to be used anyway. This criteria is as follows: 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, there has not been a one month trial of an IF unit with documentation of functional improvement, decreased pain, and evidence of medication reduction. This request is not medically necessary.