

Case Number:	CM15-0083667		
Date Assigned:	05/05/2015	Date of Injury:	08/18/2007
Decision Date:	06/04/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	05/01/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 52-year-old, female who sustained a work related injury on 8/18/07. The diagnoses have included carpal tunnel syndrome and status post left shoulder surgery. The treatments have included oral medications, topical cream, rest and left shoulder surgery. In the Treating Physician's Comprehensive Pain Management Consultation and Report dated 3/5/15, the injured worker complains of lumbar, left lower thoracic and left knee pain. She rates the discomfort an 8/10. She states pain level is 5/10 at best and 9/10 at worst. She has the pain approximately 80% of the time. She has numbness and tingling in right and left hands, left shoulder, left arm, left elbow, and left wrist. She notices this approximately 80% of the time. She has tenderness to palpation of left shoulder, left clavicle, left arm and left wrist. She has decreased range of motion in left shoulder. She has decreased range of motion in left wrist. The treatment plan is for a home interferential stimulator unit trial.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: Interspec Interferential (IF) II 60 day rental: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

Decision rationale: According to MTUS guidelines, 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. 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.). In this case, there is no clear evidence that the patient did not respond to conservative therapies, or have pain that limit her ability to perform physical therapy. There is no clear documentation of failure of pharmacological treatments or TENS therapy. Therefore, the request for Interspec Interferential (IF) II 60 day rental is not medically necessary.

Monthly electrical stimulator supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

Decision rationale: The request for Monthly electrical stimulator supplies is not medically necessary since the request for IF 60 day rental is not medically necessary.

2 lead per month for the left wrist: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

Decision rationale: As the request for IF stimulator was not certified, the request for 2 lead per month for the left wrist is not medically necessary.