

Case Number:	CM15-0235126		
Date Assigned:	12/10/2015	Date of Injury:	07/12/2007
Decision Date:	01/20/2016	UR Denial Date:	11/17/2015
Priority:	Standard	Application Received:	12/01/2015

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: Texas, New York, California
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 applicant is a represented 56 year-old who has filed a claim for chronic shoulder, wrist, elbow, knee, low back, and neck pain reportedly associated with an industrial injury of July 12, 2007. In a Utilization Review report dated November 17, 2015, the claims administrator failed to approve a request for 60-day rental of an interference stimulator device. The claims administrator referenced a July 13, 2015 office visit in its determination. The applicant's attorney subsequently appealed. On said July 13, 2015 office visit, the applicant reported ongoing issues with chronic shoulder, wrist, elbow, hand, low back, neck, and knee pain. The applicant was placed off of work, on total temporary disability. Physical therapy was sought, as were shoulder arthroscopy procedures. There was no seeming mention of the need for the interferential stimulator device in question. Medication selection and medication efficacy were not discussed or detailed on this date. The applicant's medication was not seemingly furnished.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF (Interferential) unit, 60 day rental: Upheld

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: No, the request for an interferential unit, 60-day rental was not medically necessary, medically appropriate, or indicated here. As noted on page 120 of the MTUS Chronic Pain Medical Treatment Guidelines, an interferential stimulator device can be employed on a 1-month trial basis in claimants in whom pain is ineffectively controlled owing to diminished medication efficacy, applicants in whom pain is ineffectively controlled owing to medication side effects and/or applicants who have a history of substance abuse which would prevent provision of analgesic medications. Here, however, the July 30, 2015 office visit at issue made no mention that the applicant is having issues with analgesic medication intolerance, analgesic medication failure, analgesic medication side effects, and/or issues with substance abuse which would prevent provision of analgesic medications. It is further noted that the 60-day rental of the interferential stimulator device represented treatment in excess of the 1-month trial suggested on page 120 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request was not medically necessary.