

Case Number:	CM14-0127849		
Date Assigned:	09/30/2014	Date of Injury:	01/18/2008
Decision Date:	10/28/2014	UR Denial Date:	07/18/2014
Priority:	Standard	Application Received:	08/11/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 66-year-old male with an injury date on 01/18/2008. Based on the 01/23/14 Qualified Medical Examination report provided patient complains of cervical pain with radiculitis, lumbar pain with sciatica, bilateral shoulder, bilateral wrist, and left knee pain. Diagnosis per treater report dated 07/09/14 are cervical spine disc bulges; lumbar spine disc bulges with radiculopathy; possible right shoulder internal derangement; probable left shoulder internal derangement; right wrist surgery; left carpal tunnel syndrome; right middle finger surgery; and other problems unrelated to current evaluation. The rationale is "Overall there is no treatment plan that has been formulated for this patient. There is no indication of this device being used as a part of a treatment plan."

IMR ISSUES, DECISIONS AND RATIONALES

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

IF unit -purchase (date of service 01/29/2014): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines interferential unit (ICF/IF) Page(s): 118 to 120.

Decision rationale: The MTUS Guidelines states, "interferential current stimulation is not recommended as an isolated intervention." MTUS also recommends "trying the unit for one-month before a home unit is provided if indicated. Indications are pain ineffectively controlled with medication; history of substance abuse; post-operative use; unresponsive to conservative measures." Review of the reports show no discussion regarding IF unit request, or a month trial of the unit. The patient is not post-operative, and does not present with any documented problems with oral medications. It is not mentioned that the patient is unresponsive to conservative treatments. The request does not meet MTUS guidelines criteria. Therefore, the retrospective request for an IF unit -purchase (date of service 01/29/2014) is not medically necessary and appropriate.