

Case Number:	CM14-0145628		
Date Assigned:	09/12/2014	Date of Injury:	11/04/2013
Decision Date:	10/14/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/08/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 38-year-old female who reported an injury on 11/04/2013; the mechanism of injury was due to transferring a patient. Diagnoses included cervical spine strain/sprain, rule out herniated cervical disc with radiculitis/radiculopathy; right shoulder parascapular strain/sprain; and mid back strain/sprain, and rule out herniated thoracic disc. Past treatments included chiropractic manipulation, acupuncture, physical therapy, and medication. Pertinent diagnostic studies and surgical history were not provided. The clinical note dated 07/29/2014 indicated the injured worker complained of pain in the midback and right shoulder, rated 5/10, which increased with activity. Physical exam revealed decreased range of motion of the spine, and tenderness to palpation in the right shoulder, and positive impingement test to the right shoulder. Her medications included Flexeril and ibuprofen 800 mg. The treatment plan included interferential unit for 2 months rental, batteries x4, and electrodes x4 packs. The rationale for treatment was not provided. The Request for Authorization form was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electrodes x 4 packs: 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
Transcutaneous electrotherapy Page(s): 118-120.

Decision rationale: As the requested intervention is not supported by the documentation, the requested ancillary service is also not supported.

IF Unit for 2 months rental: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Transcutaneous electrotherapy Page(s): 118-120.

Decision rationale: The California MTUS Guidelines indicate that patient selection criteria for interferential stimulation includes pain that is ineffectively controlled due to diminished effectiveness of medications; pain is ineffectively controlled with medications due to side effects; history of substance abuse; or unresponsive to conservative measures. If those criteria are met, then a 1 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. The guidelines also indicate that interferential current stimulation is 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 along. The injured worker complained of back and right shoulder pain rated 5/10. Physical exam revealed decreased range of motion of the spine, tenderness to palpation of the right shoulder, and positive impingement test of the right shoulder. There is a lack of clinical documentation to indicate that the injured worker was currently working and completing an exercise program, along with medications. There is also a lack of clinical documentation to indicate the injured worker's pain was ineffectively controlled with medications or that she had been unresponsive to conservative measures. Additionally, the guidelines indicate that if criteria are met, then a 1 month trial of the interferential unit may be appropriate; the request is for a 2 month rental of the unit. Therefore, the request for interferential unit for 2 months rental is not medically necessary.

Batteries x4: 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
Transcutaneous electrotherapy Page(s): 118-120.

Decision rationale: As the requested intervention is not supported by the documentation, the requested ancillary service is also not supported.