

Case Number:	CM14-0160214		
Date Assigned:	10/03/2014	Date of Injury:	05/15/2012
Decision Date:	11/06/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/30/2014

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 Occupational Medicine 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:

This is a 70-year-old female with a 5/15/12 date of injury secondary to continuous and repetitive movements. The patient was seen on 8/26/14 (the progress note was handwritten and partially illegible) with complaints of pain in the wrists bilaterally, neck, back, and bilateral knees. Exam findings revealed tenderness in the knees bilaterally right greater than left, crepitus, and limited range of motion from 0-130 degrees. There was mild tenderness to the wrists and mild decrease in range of motion in all planes. The diagnosis is bilateral wrist tendinitis, cervical strain, status post bilateral knee patellofemoral arthroplasty. Treatment to date: medications, acupuncture (authorized), PT. An adverse determination was received on 9/9/14 given the criteria for use of an IF unit were not met.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential home unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Section.

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

Decision rationale: Chronic Pain Medical Treatment Guidelines state that a one-month trial may be appropriate when 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. In this patient, there is inadequate documentation as to why she needs an IF unit. There is no indication that the patient's medications do not adequately control her pain, or that she has a history of substance abuse. In addition, she recently underwent physical therapy for her knees and acupuncture has been authorized. Therefore, the request for an interferential home unit was not medically necessary.