

Case Number:	CM14-0178463		
Date Assigned:	10/31/2014	Date of Injury:	03/31/2014
Decision Date:	12/08/2014	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	10/28/2014

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 Anesthesiology, has a subspecialty in Pain Management, 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 58-year-old female with a 3/31/14 date of injury. The mechanism of injury occurred when she was reaching over and felt pain in her hand. According to a progress report dated 9/23/14, the patient complained of mid and lower back pain, right shoulder pain, right wrist pain, and right knee pain. Objective findings: limited range of motion of right shoulder, positive impingement sing on the right, positive Hawkins, hypertonicity of the forearm musculature present in bilateral elbows, pain to palpation of right knee, limited right knee range of motion, pain to palpation of left paravertebral muscles and sacroiliac joints, limited range of motion of lumbar spine. Diagnostic impression: wrist sprain/strain, stenosing tenosynovitis, elbow/forearm sprain/strain, shoulder impingement, thoracic sprain/strain, lumbar sprain/strain, sacroiliac region sprain/strain, knee internal derangement. Treatment to date: medication management, activity modification, physical therapy. A UR decision dated 10/16/14 denied the request for IF device and supplies. This 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 alone.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF device and supplies: Upheld

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

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

Decision rationale: CA MTUS 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. However, in the reports reviewed, there is no documentation suggestive that the patient has had any recent conservative treatments that have been ineffective. There is no documentation that this patient has a history of substance abuse or has limited functional abilities. In addition, guidelines only support a one-month trial when appropriate, and there is no time-frame noted in this request. Therefore, the request for IF device and supplies is not medically necessary.