MAXIMUS Federal Services

Case Number:	CM14-0218653		
Date Assigned:	01/08/2015	Date of Injury:	04/04/2005
Decision Date:	03/06/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/30/2014

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. 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: Maryland
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 injured worker is a 41 year old male who sustained an industrial injury on 10/22/2012. He has reported increased, frequent, moderate and dull neck pain with spasms and decreased flexibility. The diagnoses have included cervical spine sp/st with spondylosis. Treatments to date have included consultations; diagnostic imaging studies; home EMS; cervical pillow; gel packs; home exercise program; and medication management. The injured worker has been classified as temporarily totally disabled and was returned to work with restrictions. The accepted body parts were noted to be for both hands/carpal tunnel. A 10/21/14 progress note states that the patient was using an interferential unit at home and it helped control her symptoms but it no longer is functioning and she has occasional flare ups. On 12/4/2014 Utilization Review non-certified, for medical necessity, the request for 1 month rental of AVID Interferential Stimulator unit with adhesive removers x 16; batteries x 12; electrodes x4; and lead wire x1, noting the MTUS and ODG Guidelines, were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Adhesive Removers times 16: Upheld

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

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

Decision rationale: The AVID IF unit is not medically necessary per the MTUS Guidelines. Therefore all related supplied such as adhesive removers times 16 are not medically necessary.

AVID IF unit: Upheld

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

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

Decision rationale: AVID IF Unit is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that the interferential unit 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. Additionally, the MTUS guidelines states that an interferential unit requires a one-month trial 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 documentation does not indicate that the patient has had this trial with outcomes of decreased medication, increased function and decreased pain. The documentation does not support the medical necessity of the AVID Interferential Unit.

Batteries times 12: Upheld

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

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

Decision rationale: The AVID IF unit is not medically necessary per the MTUS Guidelines. therefore all related supplied such as batteries times 12 are not medically necessary.

Electrodes times 4: Upheld

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

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

Decision rationale: The AVID IF unit is not medically necessary per the MTUS Guidelines. Therefore all related supplied such as electrodes times 4 are not medically necessary.

Leadwire times 1: Upheld

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

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

Decision rationale: The AVID IF unit is not medically necessary per the MTUS Guidelines. Therefore all related supplied such as leadwire times 1 are not medically necessary.