

Case Number:	CM15-0120642		
Date Assigned:	07/07/2015	Date of Injury:	03/30/2015
Decision Date:	08/04/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	06/22/2015

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: California, Indiana, New York
Certification(s)/Specialty: Internal 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 37 year old male who sustained an industrial injury on 3/30/15. Diagnoses are rotator cuff sprain, sprain shoulder, lumbar spine strain/sprain, lumbar disc displacement, and radicular syndrome of lower limbs. In a progress report dated 5/28/15, the treating physician notes subjective complaints of low back pain radiating to the left leg and right shoulder. Pain is unchanged. It is noted he does not want surgery. The injured worker complains of constant, severe, achy, sharp, stabbing right shoulder pain radiating to the neck. The lumbar spine exam reveals tenderness to palpation of the bilateral sacroiliac joints and L5-S1 spinous processes. Lasegue's is positive bilaterally. The right shoulder exam reveals tenderness to palpation of the anterior and posterior shoulder. Work status is modified duty. The treatment plan is to recommend Motrin 800 mg, Prilosec 20mg, Flurbi (NAP)-Cream-LA, physiotherapy 2 times per week for 4 weeks, epidural injection to the lumbar spine, and an Interferential Unit to be used at home. The treatment requested is an Interferential Unit, 5-month rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF unit 5 month rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Interferential therapy, Shoulder Chapter, Interferential current stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential unit Page(s): 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Interferential unit.

Decision rationale: Pursuant to the Official Disability Guidelines, Interferential unit (IF) five-month rental is not medically necessary. IF is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with the recommended treatments including return to work; exercise and medications area randomized trials have evaluated the effectiveness of this treatment. The findings from these trials were either negative or insufficient for recommendation due to poor's study design and/or methodologic issues. The Patient Selection Criteria should be documented by the medical care provider for IF to be medically necessary. These criteria include pain is ineffectively controlled due to diminished effectiveness of medications; due to side effects of medications; history of substance abuse; significant pain from post operative or acute conditions that limit the ability to perform exercise programs or physical therapy; unresponsive to conservative measures. If these criteria are met, then a one-month trial may be appropriate to permit the physician and physical therapy provider to study the effects and benefits. In this case, the injured worker's working diagnoses are rotator cuff sprain; sprain shoulder; lumbar spine strain sprain; lumbar disc displacement; and radicular syndrome lower extremities. The date of injury is March 30, 2015. The request for authorization is June 10, 2015. An initial evaluation was performed on April 23, 2015. Subjectively, the injured worker complained of low back pain and right shoulder pain. The treatment plan requested physical therapy two times per week times four weeks., an EMG of the lower extremities and an IF unit to be used at home. There is no documentation of a request for a one- month clinical trial. According to a May 28, 2015, progress note the injured worker has subjective complaints of ongoing low back pain. Objectively, there was tenderness to palpation with decreased range of motion. There was no documentation of an IF trial or documentation indicating objective functional improvement with IF use. There was a second request for physical therapy 2 times per week times 4 weeks. It is unclear whether the injured worker received the original physical therapy two times per week times four weeks. There is no documentation indicating objective functional improvement. There is no documentation demonstrating conservative (physical therapy) treatment failure. Consequently, absent clinical documentation with conservative treatment failure and a one-month IF trial, Interferential unit (IF) five-month rental is not medically necessary.