

Case Number:	CM15-0126609		
Date Assigned:	07/13/2015	Date of Injury:	09/01/2006
Decision Date:	08/06/2015	UR Denial Date:	06/22/2015
Priority:	Standard	Application Received:	06/30/2015

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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 57 year old male who sustained an industrial injury on September 1, 2006. He has reported neck pain and has been diagnosed with degeneration of cervical intervertebral disc, cervical disc displacement, cervical radiculitis, post laminectomy syndrome, and headache. Treatment has included medications, medical imaging, and physical therapy. Inspection of the cervical spine shows asymmetry of the neck and shoulders with tilting of the head and neck to the left. There was trapezius tenderness. Tenderness was present in the trapezial area. Cervical range of motion was restricted in forward flexion, backward extension, in right lateral tilt, in left lateral tilt, in right rotation, and left rotation. The treatment request included 1-month supplies for an interferential unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Month Supplies for an IF Unit (Electrodes, Batteries and Lead Wires): Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines IF unit Page(s): 118.

Decision rationale: According to the guidelines an IF 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. In this case, the claimant had undergone therapy and used medications. Due to significant pain and functional limitations, the request for the IF unit supplies for 1 month is appropriate and medically necessary.