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| Case Number: | CM15-0067553 | | |
| Date Assigned: | 04/15/2015 | Date of Injury: | 12/14/2007 |
| Decision Date: | 05/14/2015 | UR Denial Date: | 03/13/2015 |
| Priority: | Standard | Application Received: | 04/09/2015 |

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 58 year old male, who sustained an industrial injury on 12/14/2007. He has reported injury to the neck and low back. The diagnoses have included cervical disc disorder; lumbar intervertebral disc disorder with myelopathy; rotator cuff syndrome; and status post lumbar laminectomy. Treatment to date has included medications, diagnostics, physical therapy, and surgical intervention. Medications have included Percocet and Oxycodone. A progress report from the treating provider, dated 03/05/2015, documented an evaluation with the injured worker. Currently, the injured worker complains of lumbar, sacroiliac, and sacral pain with numbness and tingling; pain in the knees, lower extremities, shoulders, elbows, and neck with numbness and tingling; and pain is rated at 8/10 at its worst, and 5/10 at best. Objective findings have included palpable tenderness to the cervical and lumbar spine and the bilateral shoulders. The treatment plan has included the request for Interferential stimulator home unit for chronic pain over 90 days, initial trial 60 days rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential stimulator home unit for chronic pain over 90 days, initial trial 60 days rental: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120.

Decision rationale: ACOEM guidelines state "Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists." MTUS further states regarding interferential units, not recommended as an isolated intervention and details the criteria for selection: 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 (e.g., repositioning, heat/ice, etc.). "If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits." While the medical documents do indicate that the pain is ineffectively controlled (9-10/10 on pain scale throughout 2012-2013), the treating physician does not specifically attribute the uncontrolled pain due to diminished effectiveness of medications or poor control of pain with medications due to side effects while on tramadol and/or pamelor. The treating physician even notes that the patient has worsening of pain without meds, which would indicate some level of pain control with the current medication. Additionally, the medical documentation does not detail any concerns for substance abuse or pain from postoperative conditions that limit ability to participate in exercise programs/ treatments. Progress notes do not detail unresponsiveness to other conservative measures such as re-positioning, heat/ice, etc. Additionally, the request is in excess of guideline recommended 30 day trail. As such, the request for Interferential stimulator home unit for chronic pain over 90 days, initial trial 60 days rental is not medically necessary.