

Case Number:	CM15-0068907		
Date Assigned:	04/16/2015	Date of Injury:	06/04/2012
Decision Date:	05/15/2015	UR Denial Date:	03/31/2015
Priority:	Standard	Application Received:	04/10/2015

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

Certification(s)/Specialty: Emergency 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 48-year-old female who sustained an industrial injury on 6/4/12. The diagnoses have included cervical radiculopathy, subacromial impingement, lumbar degenerative disc disease (DDD) and chronic pain associated with depression and sleep disorder. Treatment to date has included medications, diagnostics, activity modifications, injections, physical therapy, functional restoration program and conservative measures. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the right shoulder and Magnetic Resonance Imaging (MRI) of the cervical spine. The current medications included Norco, Gabapentin, Tramadol, Remeron and Ativan. Currently, as per the physician progress note dated 3/24/15, the injured worker had finished a functional restoration program and has not been able to find work. Magnetic Resonance Imaging (MRI) of the lumbar spine has been approved. She continues to suffer from headaches and depression. She complains of back pain with spasms and pain that shoots down the bilateral extremities. The objective findings revealed lumbar rotation was limited to the right, lumbar tenderness, absent reflexes, decreased sensory along the inner right leg and clonus was not present. The neck exam revealed decreased range of motion, absent reflexes, decreased sensory along the dorsal radial aspect of the right hand, tenderness along the rotator cuff and facets of the neck with positive facet loading, and positive impingement sign. The physician requested treatment included Interferential Unit muscle stimulator/conductive garment rental for chronic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Unit muscle stimulator/conductive garment rental: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential current stimulation Page(s): 118-120.

Decision rationale: The requested Interferential Unit muscle stimulator / conductive garment rental, is not medically necessary. CA Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy, Interferential current stimulation, Page 118-120, noted that this treatment 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... There are no published randomized trials comparing TENS to Interferential current stimulation;" and the criteria for its use are "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.)." The injured worker has back pain with spasms and pain that shoots down the bilateral extremities. The objective findings revealed lumbar rotation was limited to the right, lumbar tenderness, absent reflexes, decreased sensory along the inner right leg and clonus was not present. The neck exam revealed decreased range of motion, absent reflexes, decreased sensory along the dorsal radial aspect of the right hand, tenderness along the rotator cuff and facets of the neck with positive facet loading, and positive impingement sign. The treating physician has not documented any of the criteria noted above, nor a current functional rehabilitation treatment program, nor derived functional improvement from electrical stimulation including under the supervision of a licensed physical therapist. The criteria noted above not having been met, Interferential Unit muscle stimulator/conductive garment rental is not medically necessary.