

<b>Case Number:</b>	CM15-0079940		
<b>Date Assigned:</b>	04/30/2015	<b>Date of Injury:</b>	02/26/2014
<b>Decision Date:</b>	06/05/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/27/2015

### 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: Physical Medicine & Rehabilitation

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 58-year-old woman sustained an industrial injury on 2/26/2014. The mechanism of injury is not detailed. Diagnoses include right knee sprain/strain with arthritis, osteoarthritis, baker's cyst, ganglion cyst, and a medical meniscus cleavage tear. Treatment has included oral medications. Physician notes dated 12/5/2014 show complaints of right knee pain rated 7/10. Recommendations include acupuncture, range of motion, muscle strength testing, Motrin, and two transdermal compounds.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase of Interspec IF II and supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118.

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

**Decision rationale:** Based on the 12/05/14 progress report provided by treating physician, the patient presents with right knee pain rated 7/10. The request is for purchase of Interspec IF II

and supplies. RFA not provided. Patient's diagnosis on 10/17/14 and 12/05/14 included right knee medical meniscus cleavage tear; and right knee sprain/strain, arthritis, osteoarthritis, baker cyst and ganglion cyst. Physical examination to the right knee on 12/05/14 revealed arthritic changes, peripatellar tenderness and positive McMurray's and Varus tests. Patient medications include Motrin and transdermal compounds. Patient is temporarily totally disabled, per 10/17/14 progress report. Treatment reports were provided from 10/17/14 - 12/05/14. MTUS pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: 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. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. Progress report with the request was not provided. Treater has not discussed reason for the request, nor how the device will be used, or what body part will be treated. Medical records show the requested treatment is not intended as an isolated intervention, as the patient takes oral medication and acupuncture, as well as functional restoration program is planned, per 10/17/14 report. With regards to interferential unit, there is no evidence that pain is not effectively controlled due to the effectiveness of medication, substance abuse or pain due to postoperative conditions or unresponsiveness to conservative measures. MTUS requires 30-day rental with documentation of use and efficacy before a home unit is allowed. There is no documentation that the patient has trialed IF unit for a one-month with documentation of outcomes. This request for purchase of IF unit with supplies is not in accordance with guideline recommendations. Therefore, the request is not medically necessary.