

Case Number:	CM15-0098243		
Date Assigned:	05/29/2015	Date of Injury:	12/10/2010
Decision Date:	07/08/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	05/21/2015

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:

The injured worker is a 60 year old, female who sustained a work related injury on 12/10/10. The diagnoses have included cervical spine bulges, thoracic spine strain and lumbar disc bulge. Treatments have included medications, massage therapy, chiropractic treatments and physical therapy. In the PR-2 dated 4/22/15, the injured worker complains of pain in neck, upper and lower back. She complains of numbness and tingling in hands and feet. She complains of bowel and bladder control issues. She has diminished sensation in right shoulder, right thumb tip, and right long and small fingertips. The treatment plan includes requests for a lumbar spine block injection, for shockwave therapy to thoracic spine, for an MRI of thoracic spine, for chiropractic treatments, for an EMG of lower extremities, for an interferential unit and a referral to surgeon.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) 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 04/22/15 progress report provided by treating physician, the patient presents with pain to neck, upper and lower back. The request is for Interferential Unit. Patient's diagnosis per Request for Authorization form dated 04/22/15 includes cervical spine bulges, thoracic spine strain, and lumbar spine disc bulge. Physical examination on 04/22/15 revealed diminished light touch sensation to right lateral shoulder, right thumb tip, right long tip and right small tip. Treatments to date have included massage therapy, physical therapy, chiropractic and medications. The patient is working regular duty, per 04/22/15 report. Treatment reports were provided from 11/12/14 - 04/22/15. 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." Treater has not provided medical rationale for the request, nor indicated how the device will be used, or what body part will be treated. Treater has not indicated whether unit is for rental or purchase. Medical records show the requested treatment is not intended as an isolated intervention, as the patient's primary treating physician is a chiropractor. 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 Interferential unit purchase is not in accordance with guideline recommendations. Therefore, the request is not medically necessary.