

<b>Case Number:</b>	CM13-0004380		
<b>Date Assigned:</b>	08/05/2013	<b>Date of Injury:</b>	04/08/2013
<b>Decision Date:</b>	01/10/2014	<b>UR Denial Date:</b>	07/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in PM&R, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

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

An initial physician review notes the treating diagnoses of a lumbar sprain and left lower extremity radiculitis. That review notes that treatment notes are partially illegible, and that as of 06/24/2013 the patient had completed 11 sessions of physical therapy and noted significant decrease in left radicular symptoms and ongoing localized, left-sided, low back pain with tenderness to palpation. That physician review concluded that a heating pad was not indicated based on the treatment guidelines and that the patient did not meet the medical necessity of guidelines for interferential stimulation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Heat Pad:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), chapter on the Knee and lower back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

**Decision rationale:** ACOEM Guidelines, Chapter 3 Treatment, page 48, states, "During the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities

such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise." The medical records do not provide an alternate rationale to support the use of thermal modalities given the more extended timeframe at the time of this request. This request is not medically necessary.

**Interferential Unit for 2 months rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines Section on Interferential Stimulation, page 118, states, "There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, and medications...possibly appropriate if pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, history of substance abuse, or unresponsive to conservative measures." The medical records in this case are limited and only partially legible. These records do not outline that these clinical criteria for interferential stimulation have been met. This request is not medically necessary.

**IF supplies including Electrode packs #8, Power Pack #24, Adhesive remover towel mint #32, Leadwire #1 and tech fee:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Since an interferential stimulator unit is not medically necessary, it follows that the related supplies are not medically necessary.