

<b>Case Number:</b>	CM13-0030162		
<b>Date Assigned:</b>	11/27/2013	<b>Date of Injury:</b>	07/16/2007
<b>Decision Date:</b>	02/03/2014	<b>UR Denial Date:</b>	09/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/26/2013

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Oklahoma and Texas. 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:

The patient is a 47-year-old male who reported an injury on 07/16/2007 when he was water testing and wind blew his fall protection device and pulled him causing a muscle spasm and lumbar strain. The patient is noted to have undergone treatment with acupuncture, physical therapy, medial branch blocks and epidural steroid injections and to have undergone a lumbar anterior/posterior discectomy and fusion at L4-5 and L5-S1 in 2010. A clinical note signed by [REDACTED] dated 06/20/2013 reported the patient complained of continued pain in the low back. He reported physical therapy did not help with the pain and he had a TENS unit but did not feel it was strong enough. The patient is noted on physical exam to have a healed surgical incision, spasms painful, and limited range of motion, positive Lasegue's and straight leg raise bilaterally, motor weakness bilaterally, and decreased sensation in the S1 dermatomal pattern/distribution. At that time, an interferential stimulator was requested to help with the pain. A clinical note signed by [REDACTED] dated 07/15/2013 noted the patient complained of continued pain and discomfort in his lumbar spine which he described as dull, stabbing, and aching. He reported his pain was 7/10 and he reported difficulty with performing his job duties. He is noted to continue to have unchanged physical examination. The patient is reported to be utilizing an X 4 stimulator at that time.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**IF UNIT:** 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 Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** The patient is a 47-year-old male who reported an injury to his low back on 07/16/2007. The patient is noted to have initially treated conservatively with extensive conservative treatment and to have eventually undergone a 360 fusion at L4-5 and L5-S1 in 2010. He is reported to complain of ongoing chronic back pain which he rated 8/10 and he noted his physical therapy did not help with his pain. He reported he did not feel his TENS unit was strong enough. The patient is noted to have ongoing muscle spasms, painful and limited range of motion, with positive Lasegue's and straight leg raise bilaterally, and decreased strength of the lower extremities and decreased sensation in the S1 distribution bilaterally. The patient is noted to have had in interferential stimulator in the past. The California MTUS Guidelines state that interferential current stimulators are not recommended as an isolated intervention, noting that there is no quality evidence of effectiveness of the interferential stimulator, except in conjunction with return to work, exercises, and medication and there is only limited evidence of improvement with use of the interferential stimulator with those treatments. As the patient is not currently undergoing a functional restoration program and is reported to have been prescribed an interferential stimulator unit in the past and there is no documentation of the patient's response to that treatment, the need for an additional interferential stimulator does not meet guideline recommendations. Based on the above, the request for an IF unit is non-certified.