

<b>Case Number:</b>	CM13-0051556		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	04/19/2006
<b>Decision Date:</b>	03/11/2014	<b>UR Denial Date:</b>	11/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/14/2013

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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 58-year-old male who reported an injury on 04/19/2006. The patient is currently diagnosed with low back pain and hip pain. The patient was seen by [REDACTED] on 10/21/2013. The patient reported ongoing lower back pain with right hip pain. Physical examination revealed tenderness to palpation in bilateral lumbar paraspinal muscles, tenderness of the left SI joint and gluteal region, palpable muscle spasm, decreased lumbar range of motion, decreased strength, and decreased sensation in the L4 and L5 distribution. Treatment recommendations included continuation of "RF unit" and current medications. It is noted that on 08/20/2013, the patient was recommended by [REDACTED] to utilize an interferential stimulation unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RF unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

**Decision rationale:** California MTUS Guidelines state interferential current stimulation 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. There should be documentation that pain is ineffectively controlled due to diminished effectiveness of medications or side effects, a history of substance abuse, or significant pain from postoperative conditions. As per the documentation submitted, there is no evidence of a failure to respond to conservative measures. There is also no evidence of a satisfactory response to treatment. The patient has continuously utilized the interferential stimulation unit, and continues to report persistent lower back and right hip pain. Physical examination continues to reveal tenderness to palpation, decrease range of motion, decrease strength, and palpable muscle spasm. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified