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| <b>Case Number:</b>   | CM13-0057428 |                              |            |
| <b>Date Assigned:</b> | 12/30/2013   | <b>Date of Injury:</b>       | 02/01/2010 |
| <b>Decision Date:</b> | 05/02/2014   | <b>UR Denial Date:</b>       | 11/07/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/25/2013 |

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, 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 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/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 injured worker is a 36-year-old male who reported an injury on February 1, 2010. The mechanism of injury was not stated. Current diagnoses include lumbar spine disc syndrome without myelopathy and lumbar radiculitis with radiculopathy of bilateral lower extremities. The injured worker was evaluated on October 18, 2013. The injured worker reported persistent lower back pain with radiation to bilateral lower extremities. Physical examination revealed tenderness to palpation, diminished range of motion, positive straight leg raising, positive crossed straight leg raising, and intact sensation. Treatment recommendations included an interferential unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**INTERFERENTIAL (IF) UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

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

**Decision rationale:** The Chronic Pain Medical Treatment 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 indicating 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 indication of a failure to respond to conservative treatment. The Chronic Pain Medical Treatment Guidelines further state if the device is to be used, a one month trial should be initiated. There was no specific frequency or total duration of treatment listed in the current request. There is also no evidence of a treatment plan with the specific short and long-term goals of treatment with the interferential unit. The request for an IF unit is not medically necessary or appropriate.