

<b>Case Number:</b>	CM14-0001058		
<b>Date Assigned:</b>	01/22/2014	<b>Date of Injury:</b>	08/03/2011
<b>Decision Date:</b>	06/11/2014	<b>UR Denial Date:</b>	12/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/03/2014

### 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, has a subspecialty in Sports Medicine and is licensed to practice in 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 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 33 year old male who reported an injury on 08/03/2011 secondary to unknown mechanism of injury. The injured worker was evaluated on 10/30/2013 for reports of continued low back pain with active range of motion. The exam noted tenderness and spasms to the lumbar spine and painful range of motion. The diagnoses included thoracic strain and lumbar sprain/strain with discopathy. The treatment plan included continued medication therapy, functional rehabilitation program and an interferential stimulator unit. The request for authorization dated 11/27/2013 was in the documentation provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **PURCHASE OF A INTERFERENTIAL STIMULATOR UNIT: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-121.

**Decision rationale:** The request for purchase of an interferential stimulator unit is not medically necessary. The California MTUS Guidelines do not recommend an interferential stimulator unit as an isolated intervention. There is no quality evidence of effectiveness except in conjunction

with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. There is a significant lack of evidence of the efficacy of the conjunctive therapies and the injured worker's level of pain and functional deficits. Therefore, the request is not medically necessary.

**ELECTRODE- 4 PACK:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary durable medical equipment is not medically necessary, none of the associated equipment is medically necessary.

**BATTERIES X 10:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary durable medical equipment is not medically necessary, none of the associated equipment is medically necessary.