

<b>Case Number:</b>	CM14-0153481		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	02/06/2009
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	09/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2014

### 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 Family Medicine 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:

This is a 51-year-old male patient who reported an industrial injury on 2/6/2009, over five (5) years ago, attributed to the performance of his usual and customary job tasks. The patient complained of pain in his neck, arms, legs, and difficulty ambulating. The patient was assessed as not making any progress. The patient was referred to a neurologist but failed to keep his appointment. The patient was diagnosed with generalized pain; lumbar disc disorder with myelopathy; brachial neuritis or radiculitis otherwise not specified; thoracic or lumbosacral neuritis or radiculitis not otherwise specified; and sprain/strain of the thoracic region. The patient was prescribed an interferential muscle stimulator for home use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 AT HOME INTERFERENTIAL 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 transcutaneous electrotherapy interferential current stimulation Page(s): 115 118-121. Decision based on Non-MTUS Citation lower back chapter-interferential therapy; pain chapter-interferential current stimulation

**Decision rationale:** The request for authorization for an interferential muscle stimulator provided no objective evidence to support the medical necessity of the requested IF neuromuscular stimulator and override the recommendations of the provided evidence-based guidelines. There was no peer reviewed objective evidence that was accepted by the national medical community to support the medical necessity of the IF unit for the treatment of chronic pain to the neck and back. The request is inconsistent with the recommendations of the CA MTUS for the use of electric muscle stimulators. The request for authorization of the IF muscle stimulator was not supported with objective evidence or any clinical documentation to support the medical necessity of this device for the treatment of the neck and upper back. There is no demonstrated medical necessity for the use of this specific electrical stimulator. As outlined below, the ACOEM Guidelines 2nd edition states that there is insufficient evidence to support the use of interferential muscle stimulation. The chronic pain chapter of the ACOEM Guidelines does not recommend the use of IF Units for the treatment of chronic neck and upper back pain. The Official Disability Guidelines do not recommend the use of an Interferential Muscle stimulator unit as an isolated intervention; however, if used anyway there are certain criteria to meet prior to authorization. Evidence-based guidelines do not support the use of NMES or interferential muscle stimulation for the treatment of the neck or cervical spine, or shoulder. Since the Interferential, muscle stimulation components are not recommended by evidence-based guidelines, then the whole device is not recommended or considered to be medically necessary or reasonable for the treatment of the neck and back. The use of a neuromuscular stimulator for the reduction of pain or control spasms is not demonstrated to be medically necessary/reasonable or meet the criteria recommended by the currently accepted evidence-based guidelines. The CA MTUS does not recommend the use of Interferential Muscle Stimulators for neck, back, shoulder pain. The claims examiner reports that the low back is not accepted as part of this industrial claim. The CA MTUS and the Official Disability Guidelines only recommend the use of the TENS unit for chronic lower back pain with a demonstrated exercise program for conditioning and strengthening. The TENS Unit is recommended for only chronic intractable pain. The Official Disability Guidelines state that there is insufficient evidence to support the use of the requested IF unit for the treatment of subacute thoracic and low back pain. There was no provided documentation that the patient was participating in a self-directed home exercise program for the effects of the industrial injury. The ACOEM Guidelines revised back chapter 4/07/08 does recommend the use of the Tens Unit for the treatment of chronic lower back pain; however, it must be as an adjunct to a functional rehabilitation program and ongoing exercise program. The CA MTUS and the Official Disability Guidelines only recommend the use of the Tens Unit for chronic lower back pain with a demonstrated exercise program for conditioning and strengthening. There are no recommendations for the use of the IF Electrical muscle stimulator unit in the treatment of chronic neck and back pain. The evidence-based guidelines discuss the ineffectiveness/side effects of medications; history of substance abuse; or an inability to respond to conservative treatment or perform physical therapy, which are not documented by the requesting physician. There is no demonstrated medical necessity for the rental of the interferential muscle stimulator with supplies/electrodes.