

<b>Case Number:</b>	CM14-0155493		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	06/14/2014
<b>Decision Date:</b>	10/31/2014	<b>UR Denial Date:</b>	08/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2014

### 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 Anesthesiologist, has a subspecialty in Pain Medicine 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 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 30-year-old male with a reported date of injury on 06/14/2014. The mechanism of injury was noted to be a motor vehicle accident. His diagnoses were noted to include cervical spine musculoligamentous sprain/strain, lumbar spine musculoligamentous sprain/strain, with right lower extremity radiculitis, right knee sprain/patellofemoral arthralgia, with history of right knee contusion, and headaches. His previous treatments were noted to include medications. The progress note dated 07/23/2014 revealed complaints of neck pain, low back pain that radiates to the lower extremity, right knee pain, and headaches. The physical examination revealed tenderness to palpation to the cervical spine with spasm present over the paraspinal musculature and trapezius muscles bilaterally. The axial compression test elicited localized pain. The range of motion to the cervical spine was decreased. The physical examination of the lumbar spine revealed tenderness to palpation with spasm present over the bilateral paraspinal musculature. The straight leg raising was positive to the gluteus muscle and there was decreased range of motion. The examination of the right knee revealed tenderness to palpation over the lateral joint in the peripatellar region. The patellofemoral crepitus was present with passive ranging, and there was decreased range of motion to the knee. Sensation to the bilateral lower extremities was intact as well as the motor strength and deep tendon reflexes. The request for authorization form dated 07/23/2014 was for a home interferential unit, for pain, muscle spasms, and restricted motion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **1. 2 month rental for an avid interferential stimulator unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 167, 300. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines , Interferential Current Stimulation, pages 118-119. Page(s): 118-119..

**Decision rationale:** The request was for one 2 month rental for an avid interferential stimulator unit for pain and spasms. The injured worker has utilized medications for pain control. The California Chronic Pain Medical Treatment Guidelines do not recommend interferential current stimulation as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with the recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The findings from the trials were either negative or uninterpretable for recommendation due to poor study design and/or methodologic issues. In addition, although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy, and the therapy may vary according to the frequency of the stimulation, the pulse duration, treatment time, and electrode placement technique. While not recommended as an isolated intervention, patient selection criteria, if interferential stimulation is to be used anyway, is if pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, history of substance abuse, significant pain for postoperative conditions that limits the ability to perform exercise program/physical therapy treatment, or is unresponsive to conservative measures. If those criteria are met, then a 1 month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain, and evidence of medication reduction. There is a lack of documentation regarding conservative measures other than medications attempted. There is a lack of documentation regarding diminished effectiveness of medications and the guidelines recommend a 1 month trial to which the request exceeds guideline recommendations. Therefore, the request is not medically necessary.

## **1 Pack of electrodes x8: 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 procedure is not medically necessary, none of the associated services are medically necessary.

## **1 Adhesive removers x32: 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 procedure is not medically necessary, none of the associated services are medically necessary.

**1 Power pack batteries x24:** 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 procedure is not medically necessary, none of the associated services are medically necessary.

**1 Lead wire 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 procedure is not medically necessary, none of the associated services are medically necessary.