

<b>Case Number:</b>	CM14-0180295		
<b>Date Assigned:</b>	11/04/2014	<b>Date of Injury:</b>	04/26/1999
<b>Decision Date:</b>	12/10/2014	<b>UR Denial Date:</b>	10/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2014

### 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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 patient is a 63-year-old diabetic man who sustained a work-related injury on April 26, 1999. Subsequently, the patient developed chronic low back pain. The EMG studies performed on May 15, 2014 showed there was evidence of left chronic S1 radiculopathy and chronic right L5 radiculopathy, indicating no significant changes from the previous study. There was no evidence of lumbosacral plexopathy, peripheral neuropathy or mononeuropathy involving bilateral tibial, sural and peroneal nerves. According to a medical report dated May 15, 2014, the patient complained of low back pain radiating to bilateral lower extremities. The patient had lumbar surgery twice in the past last performed in 2001. Physical examination revealed tenderness to palpation to the lumbar paraspinal muscles. Sensation to light touch was decreased in bilateral lower extremities. DTR was symmetrical and normal in bilateral lower extremities. The patient was diagnosed with lumbar radiculitis. The provider requested authorization for Durable Medical Equipment MI (IF Unit).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Durable Medical Equipment MI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

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

**Decision rationale:** According to MTUS guidelines, Interferential Current Stimulation (ICS). 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, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodological issues. While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). There is no clear evidence that the patient did not respond to conservative therapies, or have post op pain that limit his ability to perform physical therapy. There is no clear evidence that the prescription of interferential stimulator is in conjunction with other intervention. Therefore, the prescription of Durable Medical Equipment MI is not medically necessary.