

<b>Case Number:</b>	CM14-0028598		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	11/02/2006
<b>Decision Date:</b>	07/29/2014	<b>UR Denial Date:</b>	02/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2014

### 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 and is licensed to practice in Nevada. 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 51-year-old male who was reportedly injured on 11/2/2006. The mechanism of injury was noted as a low back injury while unloading a company truck and slipped forward down a ramp. The most recent progress note, dated 2/4/2014, indicated that there were ongoing complaints of low back pain. Physical examination demonstrated tenderness and spasm to paraspinal musculature and facet joints at L3-L5, lumbar spine range of motion: Flexion 55, extension 20, lateral bending 25 and straight leg raising 75 bilaterally; deep tendon reflexes 2+ bilaterally; weakness in big toe dorsiflexion/plantar flexion and otherwise 5/5 lower extremity muscle strength bilaterally. Magnetic resonance imaging of the lumbar spine dated on/6/2009, demonstrated a 4 mm posterior disk protrusion lateralized to the right, neural foraminal and canal stenosis at L4-L5 with degenerative disc disease, facet arthropathy and hypertrophy of the ligamentum flavum. Previous treatment included physical therapy, chiropractic treatment, epidural steroid injections and medications. A request had been made for interference muscle stimulator unit and was not certified in the utilization review on 2/4/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**INTERFERENCE MUSCLE STIMULATOR 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 Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** California Medical Treatment Utilization Schedule guidelines support the use of an interferential stimulation unit only in conjunction with a functional restoration program when the guideline criteria (cited below) are met. A one-month trial is required prior to the purchase of an interference muscle unit. The medical record provided insufficient clinical data to support this request, as there was no evidence that a trial has been provided with documentation of the appropriate response to that trial. As such, the request to purchase of an interferential stimulation unit is not considered medically necessary.