

<b>Case Number:</b>	CM14-0067767		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	01/09/2013
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	05/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2014

### 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 30-year-old female patient who reported an industrial injury on 1/9/2013, 20 months ago, attributed to the performance of her usual and customary job duties. The patient was treated with anti-inflammatory medications; physical therapy; epidural steroid injections on 6/26/2013; acupuncture and activity modification. The patient was noted to have failed conservative care and subsequently underwent a right L5-S1 discectomy on data surgery 12/3/2013. The patient reported that she had postoperative rehabilitation physical therapy with almost full resolution of the numbness but continued axial low back pain. It was noted that a prior request for an H wave muscle stimulator was noncertified. The patient was requested to have an interferential muscle stimulator for the treatment of postoperative pain. The patient was documented to complain of lower back pain. The objective findings on examination included a positive straight leg raising (SLR). The diagnosis was herniated nucleus pulposus (HNP) s/p L5-S1 discectomy with data surgery 12/3/2013 with significant back pain improvement but residual leg pain; radiculitis/radiculopathy; neuropathic pain; and lumbar spine degenerative disc disease and. The treatment plan included an interferential muscle stimulator for the treatment of chronic low back pain. The patient was prescribed 5/325 mg Percocet #120; Celebrex 200 mg #30; Flexeril 10 mg #90; and Lyrica 75 mg TID PRN.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interferential Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118, 120.

**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 Official Disability Guidelines (ODG) lower back chapter-interferential therapy; pain chapter-interferential current stimulation.

**Decision rationale:** The request for authorization provided no objective evidence to support the medical necessity of the 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, back, and extremities. 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 right shoulder. 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 post-operative rehabilitation of the back. The Official Disability Guidelines do not recommended 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. The requested IF unit purchase and supplies is a multiple channel stimulator that is reported by the vendor to alternate between the use of neuromuscular stimulation for strengthening and interferential stimulations for pain relief. The IF unit was requested to treat the back of the patient. Evidence-based guidelines do not support the use of NMES or interferential muscle stimulation for the treatment of the neck or cervical spine, shoulder or forearm. Since the IF unit is a multiple channel stimulator and the NMES and 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 shoulder. 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 recommends 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, back, or shoulder 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 purchase or rental of the interferential muscle stimulator with supplies.