

<b>Case Number:</b>	CM14-0121219		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	10/31/1994
<b>Decision Date:</b>	12/07/2015	<b>UR Denial Date:</b>	07/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/31/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
State(s) of Licensure: California, Indiana, New York  
Certification(s)/Specialty: Internal Medicine

### 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 83 year old, male who sustained a work related injury on 10-31-94. A review of the medical records shows he is being treated for neck and low back pain. In the progress notes dated 5-7-14 and 6-12-14, the injured worker reports he is disappointed that his medications and physical therapy have not been approved. He is angry that therapy has been denied. He reports his pain is "continuously severe and intolerable." He is requesting a replacement interferential unit since his is not working. On physical exam dated 6-12-14, his cervical spine and lumbar spine ranges of motion are decreased with tenderness. He has referred back pain with performing straight leg raise bilaterally. Treatments have included a lumbar support, pool therapy and medications. Current medications include Tizanidine, Butrans patches, Hydrocodone, Nexium, and Ambien. No notation of working status or retirement. The treatment plan includes requests for a replacement interferential unit, ongoing request for pool therapy and medications. The Request for Authorization dated has requests for In the Utilization Review dated 7-8-15, the requested treatment of a replacement of home interferential unit for the lumbar and cervical spine as an outpatient is not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Replacement of Home Interferential Unit for Lumbar/Cervical Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Interferential (IF) unit.

**Decision rationale:** Pursuant to the Official Disability Guidelines, replacement home Interferential unit (IF) for the lumbar spine and cervical spine is not medically necessary. IF is not recommended 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 area randomized trials have evaluated the effectiveness of this treatment. The findings from these trials were either negative or insufficient for recommendation due to poor's study design and/or methodologic issues. The Patient Selection Criteria should be documented by the medical care provider for IF to be medically necessary. These criteria include pain is ineffectively controlled due to diminished effectiveness of medications; due to side effects of medications; history of substance abuse; significant pain from post operative or acute conditions that limit the ability to perform exercise programs or physical therapy; unresponsive to conservative measures. If these criteria are met, then a one-month trial may be appropriate to permit the physician and physical therapy provider to study the effects and benefits. In this case, the injured worker's working diagnoses are cervical stenosis with multilevel severe the generative disc disease; lumbar spine spondylosis with spinal stenosis; bilateral shoulder impingement; and atrial fibrillation/coronary artery disease. Date of injury is October 31, 1994. Request for authorization is dated June 30, 2014. According to a progress note dated February 27, 2014, there was no objective progress with ongoing physical therapy. According to a June 12, 2014 progress note, the injured worker needs replacement of a nonfunctioning IF unit. There are no subjective musculoskeletal complaints in the progress note. Objectively, the injured worker ambulates with a cane with a stiff gait. There is decreased range of motion at the cervical and lumbar spine with tenderness. There is positive straight leg raising. There is no documentation demonstrating objective functional improvement with prior IF unit use. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation demonstrating objective functional improvement and no subjective musculoskeletal complaints, replacement home Interferential unit (IF) for the lumbar spine and cervical spine is not medically necessary.