

<b>Case Number:</b>	CM14-0206607		
<b>Date Assigned:</b>	12/18/2014	<b>Date of Injury:</b>	04/01/2004
<b>Decision Date:</b>	02/10/2015	<b>UR Denial Date:</b>	11/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2014

### 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 Rehab, has a subspecialty in Interventional Spine 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:

The patient is a 50 year old male with an injury date of 04/01/04. Per the 10/29/14 report the patient presents with intermittent lower back and bilateral knee pain with occasional numbness and tingling in the lower back and bilateral legs. The worst pain is in the lower back with frequent spasms. He also presents with neck and right shoulder pain. Pain is rated 10/10. He has depression and sleep issues due to chronic pain with decreased ability to do daily tasks. The patient is not working. Examination reveals neck flexion to 25 degrees and extension to 25 degrees. Right upper extremity laterally abducts to 20 degrees with lumbar flexion to 45 and extension to 15 degrees. There is weight gain of 50 pounds since the injury. The patient's diagnoses include:1. Discogenic lumbar condition with disc disease and extrusion at L4-L5 MRI being many years old2. Discogenic cervical condition with MRI showing disc disease at C5-C6 and C6-C7 with herniation at those levels3. Internal derangement of the knee on the left per MRI of 2008 showing ACL abnormality. Donjoy brace not provided and not responded upon.4. Impingement syndrome of the shoulder on the right with MRI showing partial rotator cuff tear, treated conservatively to date5. Chronic pain syndromeThe patient is prescribed Tramadol ER that the patient states decreases pain some and Flexeril which helps decrease intensity and frequency of spasms. Other medications are listed as: Protonix, Lidopro, and Effexor and Trazodone for depression. He also uses ice and heat for pain as needed. The patient's back brace is old and worn out and no longer provides proper support. The utilization review dated 11/11/14 denied this request due to lack of documented improvement with rental trial or with use of similar devices in physical therapy and lack of active rehabilitation or home exercise programs. One report is provided for review dated 10/29/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Durable Medical Equipment (DME): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS and IF Units.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS)TENS, chronic pain (transcutaneous electrical nerve st.

**Decision rationale:** The patient presents with lower back pain radiating to the bilateral legs along with pain in the bilateral knees, neck and right shoulder in addition to sleep difficulty and depression. Worst pain is in the lower back rated 10/10. The current request is for Durable Medical Equipment (DME). The request as presented above is not clear. Per the 11/11/14 utilization review and the 10/29/14 RFA the request is for IF or Muscle Stimulator. MTUS pages 118 to 120 states that Interferential Current Stimulation (ICS) are not recommended as an isolated intervention. MTUS further states, "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway." It may be appropriate if pain is not effectively controlled due to diminished effectiveness or side effects of medication; history of substance abuse, significant pain due to postoperative conditions; or the patient is unresponsive to conservative measures. A one month trial may be appropriate if the above criteria are met. MTUS, TENS, chronic pain (transcutaneous electrical nerve stimulation)(p114-116) states, "Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. MTUS further states use is for neuropathic pain. The treater does not discuss the request for an IF unit in the sole report provided dated 10/29/14; however, the treatment plan does state that a TENS unit was previously recommended or requested and states, "Please authorize." In this case, the patient is undergoing a regimen of medications and uses heat and ice for pain, and the requested units are not an isolated intervention or primary treatment modality. However, it is unclear if an Interferential unit or TENS unit is requested or the request is an indeterminate request for either unit. Furthermore, while a 30 day trial of either unit may be appropriate, it is not stated if the request is for purchase or 30 day trial. Lacking a clear statement of the request, the request is not medically necessary.