

<b>Case Number:</b>	CM14-0209670		
<b>Date Assigned:</b>	12/22/2014	<b>Date of Injury:</b>	07/30/2014
<b>Decision Date:</b>	02/13/2015	<b>UR Denial Date:</b>	11/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/15/2014

### 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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 38-year-old male with a 7/30/14 date of injury. At the time (11/10/14) of request for authorization for Interferential Stimulator x 1 month rental and Supplies: Electrodes Packs (x4), Power Packs (x12), Adhesive Remover Towel Mint (x16), Leadwire (x1), there is documentation of subjective (low back pain radiating to the left hip/buttock extending to the lower leg with numbness to the lateral and anterior aspects of the thigh; mid and upper back pain, and increased neck pain extending to the right shoulder with numbness and stiffness) and objective (tenderness to palpation over the cervical paravertebral musculature and right trapezius muscle with muscle spasm and decreased range of motion; tenderness to palpation over the thoracic paravertebral musculature with muscle guarding and decreased lumbar range of motion; tenderness to palpation over the lumbosacral junction, left sciatic notch, and left gluteal musculature with muscle spasm and decreased range of motion, positive straight leg raise, decreased sensation over the L3 and L4 dermatomal distributions, and 1+ reflexes of the biceps, triceps and brachioradialis) findings, current diagnoses (lumbar sprain/strain, left lower extremity radiculitis, cervical/trapezial sprain/strain, and right upper extremity radiculitis), and treatment to date (activity modification). Medical report identifies a request for physical therapy, medications, and home interferential unit. There is no documentation of limited evidence of improvement on recommended treatments (return to work, exercise and medications) alone.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interferential (IF) Stimulator times 1 month rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identify that interferential current stimulation is not recommended as an isolated intervention and that 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. Within the medical information available for review, there is documentation of diagnoses of lumbar sprain/strain, left lower extremity radiculitis, cervical/trapezial sprain/strain, and right upper extremity radiculitis. In addition, given documentation of a request for physical therapy, medications, and home interferential unit, there is documentation that the IF unit will be used in conjunction with recommended treatments (exercise and medications). However, there is no documentation of limited evidence of improvement on recommended treatments (return to work, exercise and medications) alone. Therefore, based on guidelines and a review of the evidence, the request for interferential stimulator times 1 month rental is not medically necessary.

**Supplies: Electrodes Packs (times 4), Power Packs (times 12), Adhesive Remover Towel Mint (times 16), Leadwire (times 1):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identify that interferential current stimulation is not recommended as an isolated intervention and that 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. Within the medical information available for review, there is documentation of diagnoses of lumbar sprain/strain, left lower extremity radiculitis, cervical/trapezial sprain/strain, and right upper extremity radiculitis. In addition, given documentation of a request for physical therapy, medications, and home interferential unit, there is documentation that the IF unit will be used in conjunction with recommended treatments (exercise and medications). However, there is no documentation of limited evidence of improvement on recommended treatments (return to work, exercise and medications) alone. Therefore, based on guidelines and a review of the evidence, the request for the supplies is not medically necessary.

