

<b>Case Number:</b>	CM15-0001376		
<b>Date Assigned:</b>	01/12/2015	<b>Date of Injury:</b>	10/06/2014
<b>Decision Date:</b>	03/06/2015	<b>UR Denial Date:</b>	12/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/05/2015

### 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

Certification(s)/Specialty: Preventive Medicine, Occupational 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 22 year old female, who sustained an industrial injury to her lower back and heard a "pop" in the right hand after trying to prevent recyclables from falling on 10/6/14. She has reported persistent right wrist hand pain and swelling, as well as increasing low back pain with radiation down the right buttocks to foot. The diagnoses have included cervical/trapezial musculoligamentous sprain/strain, thoracic musculoligamentous sprain/strain, lumbar musculoligamentous sprain/strain and right lower extremity radiculitis, and right wrist/hand sprain. Treatment to date has included medications, diagnostics, chiropractic sessions and physical therapy. Currently as per the physician's first report dated 11/25/14, the IW complains of constant low back pain radiating to right lower extremity/foot with burning and numbness, neck pain, mid and upper back pain, right wrist/hand pain and slight swelling. The cervical spine x-ray revealed complete straightening of the lordosis. Upon exam of the cervical spine there was tenderness to palpation over the paravertebral musculature and paraspinal muscle guarding was present. Axial compression test elicited localized neck pain. There is tenderness to palpation over the paravertebral musculature and lower thoracic spine. The lumbar spine revealed paraspinal muscle guarding with palpation. Straight leg raising test was positive eliciting increased low back pain with radiation to right buttock/posterior thigh. The right hand/wrist revealed slight diffuse swelling, tenderness to palpation over carpometacarpal joint. The sensation to pinprick and light touch was slightly decreased over the dorsolateral aspect right foot and ankle consistent with dermatomal disturbances. There is an initial physical therapy evaluation note for sessions 2xwk for 3 wks. Past sessions of physical therapy and chiropractic

were not noted. Current medications were not listed. On 12/23/14 Utilization Review non-certified a request for 1 home interferential unit, noting that this treatment is not recommended as an isolated intervention. If used there should be documentation that pain was ineffectively controlled due to diminished effectiveness of medications, which is not evident in this case. The IW does not meet guideline criteria for use. The MTUS Guidelines were cited.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Interferential unit for home:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 117-120.

**Decision rationale:** Due to the lack of evidence that this type of unit provides lasting benefits, MTUS Guidelines have very specific criteria that should be met prior to purchase of a home unit. These criteria include a documented successful application by a health care professional and then a well documented 1 one month trial of a home unit prior to purchase. Neither of these qualifying criteria have been met to justify purchase of a unit. The TENS unit section of the Guidelines makes it clear that electrical stimulation units are recommended for rental during this 1 month trial. Under these circumstances, the Interferential unit for home is not supported by Guidelines and is not medically necessary.