

<b>Case Number:</b>	CM15-0105095		
<b>Date Assigned:</b>	06/09/2015	<b>Date of Injury:</b>	07/09/2014
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	04/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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: Physical Medicine & Rehabilitation

### 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 41 year old male, who sustained an industrial injury on 7/9/14. The injured worker was diagnosed as having cervical intervertebral disc disorder with myelopathy, lumbar intervertebral disc disorder with myelopathy and rotator cuff syndrome of shoulder. Treatment to date has included physical therapy, home exercise program, topical compound and oral pain medications. Currently, the injured worker complains of lumbar, left and left sacroiliac, sacral, cervical dorsa, right mid thoracic, right pelvic, right buttock, right posterior leg, right posterior knee, right hip and right anterior leg pain rated 7/10. He notes improvement in pain with physical therapy, topical compound and pain medication. Physical exam noted tenderness to palpation at lumbar, left pelvic, left and right sacroiliac, sacral, left buttock, right buttock, right pelvic, left posterior leg, right posterior leg, right posterior knee, left posterior knee, left calf, right calf, right ankle, right foot, left ankle and left foot. Restricted lumbar range of motion is also noted. A request for authorization was submitted for interferential stimulator home unit for chronic pain for greater than 90 days.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interferential stimulator home unit, initial trial 60 days: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, pages 115-118.

**Decision rationale:** The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage, increased pain relief or improved functional status derived from any transcutaneous electrotherapy to warrant a purchase of an interferential unit for home use for this chronic injury. Additionally, IF unit may be used in conjunction to a functional restoration process with improved work status and exercises not demonstrated here. The interferential stimulator home unit, initial trial 60 days is not medically necessary and appropriate.