

<b>Case Number:</b>	CM15-0136500		
<b>Date Assigned:</b>	07/24/2015	<b>Date of Injury:</b>	10/25/2010
<b>Decision Date:</b>	08/21/2015	<b>UR Denial Date:</b>	07/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 57-year-old female, who sustained an industrial injury on October 25, 2010. Treatment to date has included diagnostic imaging, home exercise program, and medications. Currently, the injured worker complains of worsened pain. She reports neck pain and spasms and rates her pain a 6-7 on a 10-point scale with medications and 9-10 on a 10-point scale without medications. She requests stronger medications and requests a Toradol injection. On physical examination, the injured worker exhibits normal reflex, sensory and power testing of the bilateral upper extremities and the bilateral lower extremities with the exception of numbness and weakness of C6 and C7. She has negative straight leg raise tests and bowstring tests bilaterally and exhibits a normal gait. She has tenderness to palpation over the cervical and lumbar spine and has decreased lumbar spine range of motion. She has posterior cervical and lumbar spine spasms. The diagnoses associated with the request include displacement of cervical intervertebral disc without myelopathy, C5-6 and C6-7 bulge and herniated nucleus pulposus, and cervical and lumbar strain. The treatment plan includes interferential unit, urine drug screen and continuation of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interferential unit:** Upheld

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

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

**Decision rationale:** According to MTUS guidelines, "Interferential Current Stimulation (ICS). Not recommended as an isolated intervention. 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. (Van der Heijden, 1999)(Werner, 1999) (Hurley, 2001) (Hou, 2002) (Jarit, 2003) (Hurley, 2004) (CTAF, 2005) (Burch, 2008) The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.)." There is no clear evidence that the patient did not respond to conservative therapies, or have post op pain that limit his ability to perform physical therapy. There is no clear evidence that the neurostimulator will be used as a part of a rehabilitation program. There is evidence of prior effective trial. Therefore, the request for Interferential unit is not medically necessary.

**Full panel drug screen (DOS 6/29/15):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/addiction Page(s): 77-78; 94.

**Decision rationale:** According to MTUS guidelines, urine toxicology screens are indicated to avoid misuse/addiction. "(j) Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs." There is no evidence that the patient have aberrant behavior for urine drug screen. There is no clear evidence of abuse, addiction and poor pain control. There is no documentation that the patient has a history of use of illicit drugs. The patient last urine drug screen performed on June 29 2015 was negative for drug abuse. Therefore, the request for Full panel drug screen (DOS 6/29/15) is not medically necessary.