

<b>Case Number:</b>	CM15-0161217		
<b>Date Assigned:</b>	08/28/2015	<b>Date of Injury:</b>	11/02/2007
<b>Decision Date:</b>	09/30/2015	<b>UR Denial Date:</b>	08/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2015

### 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: Emergency 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 53 year old male, who sustained an industrial injury on 11-2-07. He has reported initial complaints of a low back injury. The diagnoses have included lumbar facet arthropathy, chronic pain status post lumbar fusion, lumbosacral spondylosis without myelopathy and thoracic or lumbosacral neuritis or radiculitis. Treatment to date has included medications, activity modifications, diagnostics, surgery, physical therapy, injections, and other modalities. Currently, as per the physician progress note dated 7-21-15, the injured worker complains of low back pain that radiates to the left lower extremity (LLE) with numbness in the bilateral lower extremities (BLE) and feet, burning at the surgical site and popping and crackling sound in his back associated with severe pain. The injured worker reports ongoing activities of daily living (ADL) limitations and pain that is rated 10 out of 10 over the past month. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the lumbar spine. The current medications included Gabapentin, Mirtazapine, Ondansetron, Pantoprazole, Zolpidem, Hydrocodone-Acetaminophen, and Orphenadrine, Lidocaine patch, MS Contin and Bio freeze gel. The objective findings-physical exam reveals lumbar spasm is noted, tenderness to palpation, limited lumbar range of motion due to pain, pain was increased with flexion and extension, and straight leg raise in the seated position was positive bilaterally at 50 degrees. The physician requested treatment included Purchase Interferential Unit (IF) Unit and Supplies.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase IF Unit and Supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential current stimulation, Page 118-120 Page(s): 118-120.

**Decision rationale:** The requested Purchase IF Unit and Supplies, is not medically necessary. CA Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy, Interferential current stimulation, Page 118-120, noted that this treatment is "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... There are no published randomized trials comparing TENS to Interferential current stimulation;" and the criteria for its use are: "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)." The injured worker has low back pain that radiates to the left lower extremity (LLE) with numbness in the bilateral lower extremities (BLE) and feet, burning at the surgical site and popping and crackling sound in his back associated with severe pain. The treating physician has documented lumbar spasm is noted, tenderness to palpation, limited lumbar range of motion due to pain, pain was increased with flexion and extension, and straight leg raise in the seated position was positive bilaterally at 50 degrees. The treating physician has not documented any of the criteria noted above, nor a current functional rehabilitation treatment program, nor derived functional improvement from electrical stimulation including under the supervision of a licensed physical therapist. The criteria noted above not having been met, Purchase IF Unit and Supplies is not medically necessary.