

Case Number:	CM15-0169264		
Date Assigned:	09/09/2015	Date of Injury:	02/26/2015
Decision Date:	10/08/2015	UR Denial Date:	07/29/2015
Priority:	Standard	Application Received:	08/27/2015

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: Texas, California

Certification(s)/Specialty: Family Practice

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 47 year old female, who sustained an industrial injury on February 26, 2015. The mechanism of injury was a trip and fall. The injured worker aggravated pre-existing conditions of her neck, back and right hip. The diagnoses have included lumbar disc protrusion, lumbar radiculopathy, cervical sprain-strain, lumbar sprain-strain, thoracic sprain-strain, sprains of the hip and thigh, anxiety, depression and insomnia. The injured worker was noted to be temporarily totally disabled. Current documentation dated June 25, 2015 notes that the injured worker reported low back pain radiating to the left foot and neck, mid-back, left knee and right hip pain. Examination of the cervical and thoracic spine revealed tenderness to palpation, muscle spasm of the paravertebral muscles and a decreased range of motion. A cervical compression test caused pain. Examination of the lumbar spine revealed tenderness to palpation, muscle spasm of the paravertebral muscles and a decreased range of motion. A straight leg raise test was positive on the left. Right hip examination revealed tenderness to palpation and a decreased range of motion. Examination of the left knee revealed tenderness to palpation, a decreased range of motion and a positive McMurray's test. Treatment and evaluation to date has included radiological studies (4-27-2015), cardio-respiratory studies, Sudoscan, MRI of the lumbar spine (5-13-2015) and physical therapy. The MRI (5-13-2015) of the lumbar spine revealed posterior disc bulges and mild left neural foraminal narrowing. Current medications include creams, Ibuprofen and Lactulose. The treating physician's request for authorization dated July 13, 2015 included a request for the purchase of a multi-stimulation unit-interferential unit for low back. The original Utilization Review dated July 29, 2015 non-certified the request for the purchase of

a multi-stimulation unit-interferential unit for low back due to the unit not being recommend as an isolated intervention. The patient had received an unspecified number of PT visits for this injury. The medication list include Meloxicam. On review of systems the patient does not have any complaints of gastrointestinal tract.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of multi-stimulation unit-interferential unit for low back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: Request: Purchase of multi-stimulation unit-interferential unit for low back. Per the CA MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS) 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." Per the cited guideline "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.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction." According the cited guidelines, electrical stimulation (TENS), is "not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. While TENS may reflect the long-standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Recommendations by types of pain: A home-based treatment trial of one month may be appropriate for neuropathic pain and CRPS II (conditions that have limited published evidence for the use of TENS as noted below), and for CRPS I (with basically no literature to support use)." According the cited guidelines, Criteria for the use of TENS is "There is evidence that other appropriate pain modalities have been tried (including medication) and failed." A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. Evidence of neuropathic pain, CRPS I and CRPS II was not

specified in the records provided. The patient had received an unspecified number of PT visits for this injury. Evidence of a trial and failure of a TENS unit for this injury was not specified in the records provided. In addition a treatment plan including the specific short- and long-term goals of treatment with the TENS unit was not specified in the records provided. The response of the symptoms to a period of rest, oral pharmacotherapy is not specified in the records provided. The records provided did not specify any recent physical therapy with active PT modalities or a plan to use TENS as an adjunct to a program of evidence-based functional restoration. A evidence of diminished effectiveness of medications or intolerance to medications or history of substance abuse was not specified in the records provided. The request for Purchase of multi-stimulation unit-interferential unit for low back is not medically necessary for this patient.