

<b>Case Number:</b>	CM15-0186888		
<b>Date Assigned:</b>	09/28/2015	<b>Date of Injury:</b>	09/15/2014
<b>Decision Date:</b>	12/15/2015	<b>UR Denial Date:</b>	08/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2015

### 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, Pain Management, 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 35 year old female, who sustained an industrial injury on 9-15-14. The documentation on 9-15-14 noted that the injured worker has complaints of low back. Examination of the back revealed no spam and there is 60 degrees of flexion and 10 degrees of extension. Straight leg raise was negative; ankle dorsi and plantar flexors were 5 out 5; quadriceps was 5 out of 5 and iliopsoas was 5 out of 5. The diagnoses have included sprain of lumbar. Magnetic resonance imaging (MRI) of the lumbar spine on 8-17-15 showed a 4 millimeter bulging disc, L4-5 and there was no significant difference between it and the one prior. Treatment to date has included physical therapy with no progression and acupuncture. The documentation on 8-20-15 noted that the injured worker has undergone five sessions of physical therapy with two more sessions. Disability status is noted to permanent and stationary. The original utilization review (8-27-15) non-certified the request for retrospective interferential unit (purchase) for the lumbar spine date of service 6-13-15; retrospective lead wire date of service 6-13-15; retrospective electrodes (three inches and two inches) date of service 6-13-15; retrospective batteries date of service 6-13-15 and retrospective AOH wipes date of service 6-13-2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective IF Unit (purchase) for the lumbar spine DOS: 6/13/2015: 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): Electrical stimulators (E-stim).

**Decision rationale:** MTUS 2009 does not support the use of electrical stimulation unit as an isolated intervention. There is no treatment plan in which this electrical stimulation unit is incorporated. The patient's condition is considered to have reached maximum medical improvement. There does not appear to be a role for electrical stimulation in the ongoing care of this patient. The use of an electrical stimulation unit is not supported by evidence-based guidelines in this case and is not medically necessary.

**Retrospective Lead Wire DOS: 6/13/2015: 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): Electrical stimulators (E-stim).

**Decision rationale:** MTSUS 2009 does not support the use of electrical stimulation units as an isolated intervention. The electrical stimulation unit is not medically necessary and therefore replacement parts are not medically necessary.

**Retrospective Electrodes (three inches and two inches) DOS: 6/13/2015: 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): Electrical stimulators (E-stim).

**Decision rationale:** MTUS 2009 states that electrical stimulation units should not be used as part as an isolated intervention. The electrical stimulation unit is not medically necessary and replacement parts are therefore not needed. This request for replacement electrodes is not medically necessary.

**Retrospective Batteries DOS: 6/13/2015: 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): Electrical stimulators (E-stim).

**Decision rationale:** MTUS 2009 states that an electrical stimulator should not be used as an isolated intervention. Since the electrical stimulation unit is not medically necessary, the request for a replacement battery is not medically necessary.

**Retrospective AOH wipes DOS: 6/13/2015:** 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): Electrical stimulators (E-stim).

**Decision rationale:** MTUS 2009 states that electrical stimulators should not be used as an isolated intervention. The electrical stimulation unit has been determined to be not medically necessary. Therefore, surface wipes to clean the skin surface for application of the electrodes are not medically necessary.