

<b>Case Number:</b>	CM15-0205027		
<b>Date Assigned:</b>	10/21/2015	<b>Date of Injury:</b>	03/29/2013
<b>Decision Date:</b>	12/03/2015	<b>UR Denial Date:</b>	09/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/19/2015

### 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 58 year old female who sustained an industrial injury March 29, 2013. According to the only primary treating physician's progress report dated June 16, 2015, the injured worker presented with complaints of lower back pain with radicular symptoms into the right leg, aggravated by prolonged sitting, standing, and walking. She also reported that sneezing and coughing increases her pain as well as lifting. Objective findings included; lumbar spine-straight leg raise positive at 75 degrees right, tightness and spasm in the bilateral paraspinal musculature, hypoesthesia along the anterior lateral aspect of the foot and ankle, L5 and S1 dermatome bilaterally, weakness with big toe dorsiflexion and plantar flexion bilaterally; tenderness over the greater trochanteric bursa of the right femur. Diagnoses are sprain, strain right hip, rule out internal derangement; herniated lumbar disc with radiculitis-radiculopathy right greater than left per MRI; sprain, strain right knee; sprain, strain left ankle. Treatment plan included to continue with current medication, continue home therapy and stretching exercises, heating pad, physical therapy for the lumbar spine and right hip and ultrasound guided cortisone injection for the right hip, pending authorization. At issue, is the request for authorization for an IF (interferential unit) 5 month rental. A report of an MRI of the lumbar spine dated June 3, 2015, is present in the medical record. According to utilization review dated September 28, 2015, the request for an IF unit, 5 month rental is non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**IF Unit 5 month rental:** 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:** The requested IF Unit 5 month rental, 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 lower back pain with radicular symptoms into the right leg, aggravated by prolonged sitting, standing, and walking. She also reported that sneezing and coughing increases her pain as well as lifting. Objective findings included; lumbar spine- straight leg raise positive at 75 degrees right, tightness and spasm in the bilateral paraspinous musculature, hypoesthesia along the anterior lateral aspect of the foot and ankle, L5 and S1 dermatome bilaterally, weakness with big toe dorsiflexion and plantar flexion bilaterally; tenderness over the greater trochanteric bursa of the right femur. 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, IF Unit 5 month rental is not medically necessary.