

<b>Case Number:</b>	CM15-0035717		
<b>Date Assigned:</b>	03/04/2015	<b>Date of Injury:</b>	08/07/2014
<b>Decision Date:</b>	04/15/2015	<b>UR Denial Date:</b>	02/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2015

### 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

### 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 34-year-old female, who sustained an industrial injury on 8/07/2014, when lifting a heavy box. The diagnoses have included thoracic or lumbosacral neuritis or radiculitis, unspecified. Treatment to date has included conservative measures. X-rays of the cervical and thoracic spines, dated 1/14/2015, were negative. A hospital report, dated 1/14/2015, noted that lumbar x-rays were performed and negative. Currently, the injured worker complains of diffuse neck pain, with associated numbness into both upper extremities, and low back pain, with associated numbness into both lower extremities to the knees. She reported anxiety, depression, eating disorder, and insomnia. Medications included Percocet, Soma, Motrin, and Lodine. She was currently not working. Exam of the cervical spine noted positive Spurling's test and decreased range of motion. Upper extremity motor strength noted 4+/5 right deltoid and 4+/5 bilateral triceps. Sensation was decreased bilaterally in the C5-6 distribution. Exam of the lumbar spine noted midline and lumbosacral junction tenderness, along with decreased range of motion. Sensory of the right L5 distribution was decreased and straight leg raise test was positive on the right at 30 degrees. Previous physical therapy, including a good response to a muscle stimulator, was documented. Physical therapy progress note, dated 1/07/2015 and noted as visit #16, was submitted. On 2/12/2015, Utilization Review non-certified a request for durable medical equipment, MEDS 4 INF + interferential unit/garment, noting the lack of compliance with MTUS/ACOEM Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MEDS 4 INF interferential unit/garment:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 116-118.

**Decision rationale:** The 34-year-old patient complains of moderate to severe and diffuse neck pain and back pain along with numbness in bilateral upper and lower extremities, as per progress reports dated 01/27/15. The request is for meds 4 INF interferential unit/garment. The RFA for the case is dated 02/04/15, and the patient's date of injury is 08/07/14. Diagnoses included lumbar and cervical radiculopathy, as per progress report included 01/27/15. The patient is not working, as per the same progress report. For Interferential Current Stimulation (ICS), MTUS guidelines state, "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." These devices are recommended in cases where (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or (4) Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (5) 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. In this case, the request for the IF unit is noted in progress report dated 01/27/14. The treater states that the IF unit will help "improve his circulation and range of motion through muscle reduction as well as to help with pain control and decrease the need for medications." The treating physician also states that the patient is suffering from pain in spite of therapy, chiropractic care, and medications. Given the patient's lack of response to conservative care and continued use of other treatments modalities, a one-month trial may be appropriate, but this request is for a purchase of the unit. The current request is not medically necessary, as there has not been a one-month trial showing functional improvement, reduction of pain and reduction of medication usage.