

<b>Case Number:</b>	CM15-0085790		
<b>Date Assigned:</b>	05/07/2015	<b>Date of Injury:</b>	07/06/2011
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	04/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/04/2015

### 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: New Jersey, New York  
 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 57 year old female, who sustained an industrial injury on 7/06/2011, after a fall. The injured worker was diagnosed as having cervical spondylosis without myelopathy, tendinitis of rotator cuff, and lumbosacral spondylosis. Treatment to date has included diagnostics, cervical spinal fusion in 2012, right shoulder surgery 3/04/2015, physical therapy, transcutaneous electrical nerve stimulation unit, multiple injections to the back, and medications. Currently, the injured worker reported unchanged low back pain. She reported a fall one week after her shoulder surgery, due to left leg numbness, hitting her left knee. She reported using sling for her shoulder, causing aggravation of her neck pain. She reported being given a muscle stimulation unit over 2 years prior but it was now broken. She reported pain relief and medication reduction while she used this device. Physical exam noted decreased cervical range of motion. Inspection of the lumbar spine noted normal lordosis, decreased range of motion, and no pain on palpation or significant paraspinal muscle spasm. Straight leg raise test was positive bilaterally. Severe tension signs were noted in bilateral lower extremities with paresthesias and dysesthesias in the anterior thigh bilaterally. Weakness was noted in bilateral iliopsoas, tibialis anterior, gastroc soleus, and right extensor hallucis longus. Current medication use was not noted and work status was total temporary disability. The treatment plan included a Meds-4 interferential unit for neck and back pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Meds 4 IF Unit for Neck and Back Pain:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

**Decision rationale:** The request for ICS is considered not medically necessary. The patient does not meet selection criteria. She is not documented to have failed all conservative therapy. There is no documentation that her pain was not controlled by medications or she suffered side effects that would prevent him from continuing medications. The patient has used ICS but does not have documented increased functional improvement and less pain, with evidence of medication reduction would be necessary before prescribing another unit. Therefore, the request is not medically necessary.