

<b>Case Number:</b>	CM14-0131222		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	05/01/2004
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	07/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/15/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 73-year-old male who sustained multiple injuries on 5/1/04 after falling off a truck. He was previously diagnosed with acromioclavicular sprain/strain, backache, limb pain, and cervical sprain/strain. The patient has been having chronic pain in his cervical spine, right shoulder, and lumbar spine. He was treated with medications, physical therapy, and acupuncture and HEP. On 5/24/13 he presented with persistent low back pain and bilateral leg pain and weakness. He also reported that he had on and off right shoulder pain. His symptoms are affecting his ADLs. Examination revealed tenderness, positive impingement sign, and restricted ROM in the right shoulder. There is lumbar spine tenderness over the right paraspinous column and painful and limited ROM. Home exercise kit and IF unit was advised. HEP and medications were continued. From the partly illegible report of 6/4/13 it is indicated that the patient was experiencing cervical spine pain, and pain in the right shoulder and lumbar spine; treatment recommendations made included home exercise kit, heat pad, and IF unit. Examination documented positive Bragard's test and tenderness over the cervical spine, right shoulder, and lumbosacral spine. It is indicated that the patient completed an in office trial of IF device and reported that it helped to moderate his pain levels on the treatments. It was further stated that he had used electrical stimulation during PT for a month or more and had found it beneficial. The request for UR for one interferential unit purchase with set-up and delivery to include 2 batteries and 2 electrode pads was denied due to lack of medical necessity on 7/16/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective for 06/13/2013 one interferential unit purchase with set-up and delivery to include 2 batteries and 2 electrode pads:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Interferential current stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation Page(s): 120.

**Decision rationale:** Per guidelines, Interferential Current Stimulation 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. 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. In this case, the medical records do not document this device is indicated, as the criteria are not met; therefore, the request is not medically necessary.