

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM14-0137551 |                              |            |
| <b>Date Assigned:</b> | 09/05/2014   | <b>Date of Injury:</b>       | 09/15/1985 |
| <b>Decision Date:</b> | 10/09/2014   | <b>UR Denial Date:</b>       | 08/21/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/25/2014 |

### 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 Family Medicine 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:

This is a 57-year-old female who reported an industrial injury to the neck on 9/15/1985, over 29 years ago, attributed to the performance of her usual and customary job tasks. The patient was being treated for chronic neck pain. The objective findings on examination included tenderness to palpation and muscle spasm. The diagnosis was cervical spine intervertebral disc displacement without myelopathy; cervical spine DDD; brachial neuritis or radiculitis and chronic pain. The patient was prescribed an Avid interferential muscle stimulator unit with eight (8) electrodes, 24 batteries, 32 adhesive remover patches, and one (1) lead wire.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Avid IF Unit With Electrodes 8, for 2 Month Rental: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Evidence Based Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrotherapy, interferential current stimulation Page(s): 115, 118-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) lower back chapter-interferential therapy; pain chapter-interferential current stimulation

**Decision rationale:** The request for authorization for an interferential muscle stimulator provided no objective evidence to support the medical necessity of the Avid IF neuromuscular stimulator and override the recommendations of the provided evidence-based guidelines. There was no peer reviewed objective evidence that was accepted by the national medical community to support the medical necessity of the IF unit for the treatment of chronic pain to the neck and upper back. The request is inconsistent with the recommendations of the CA MTUS for the use of electric muscle stimulators. The request for authorization of the IF muscle stimulator was not supported with objective evidence or any clinical documentation to support the medical necessity of this device for the treatment of the neck and upper back. There is no demonstrated medical necessity for the use of this specific electrical stimulator. As outlined below, the ACOEM Guidelines 2nd edition states that there is insufficient evidence to support the use of interferential muscle stimulation. The chronic pain chapter of the ACOEM Guidelines does not recommend the use of IF Units for the treatment of chronic neck and upper back pain. The Official Disability Guidelines do not recommended the use of an Interferential Muscle stimulator unit as an isolated intervention; however, if used anyway there are certain criteria to meet prior to authorization. The requested IF unit rental x 2 month with purchase of supplies is a dual channel stimulator that is reported by the vendor to alternate between the use of neuromuscular stimulation for strengthening and interferential stimulations for pain relief. The IF unit was requested to treat the back and postoperative knee of the patient. Evidence-based guidelines do not support the use of NMES or interferential muscle stimulation for the treatment of the neck or cervical spine, or shoulder. Since the Interferential, muscle stimulation components are not recommended by evidence-based guidelines, then the whole device is not recommended or considered to be medically necessary or reasonable for the treatment of the neck and upper back. The use of a neuromuscular stimulator for the reduction of pain or control spasms is not demonstrated to be medically necessary/reasonable or meet the criteria recommended by the currently accepted evidence-based guidelines. The CA MTUS does not recommend the use of Interferential Muscle Stimulators for neck, back, shoulder pain. The claims examiner reports that the low back is not accepted as part of this industrial claim. The CA MTUS and the Official Disability Guidelines only recommends the use of the TENS unit for chronic lower back pain with a demonstrated exercise program for conditioning and strengthening. The TENS Unit is recommended for only chronic intractable pain. The Official Disability Guidelines state that there is insufficient evidence to support the use of the requested IF unit for the treatment of subacute thoracic and low back pa

**Batteries x 24:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Evidence Based Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrotherapy ; interferential current stimulation Page(s): 115, 118-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) lower back chapter-interferential therapy; pain chapter-interferential current stimulation

**Decision rationale:** Since there is no medical necessity for the requested Avid interferential muscle stimulator, there is no demonstrated medical necessity for the purchase of the interferential muscle stimulator supplies.

**Leadwire x 1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Evidence Based Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrotherapy ; interferential current stimulation Page(s): 115, 118-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) lower back chapter-interferential therapy; pain chapter-interferential current stimulation

**Decision rationale:** Since there is no medical necessity for the requested Avid interferential muscle stimulator, there is no demonstrated medical necessity for the purchase of the interferential muscle stimulator supplies.

**Adhesive Wipes x 32:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Evidence Based Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrotherapy ; interferential current stimulation Page(s): 115, 118-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) lower back chapter-interferential therapy; pain chapter-interferential current stimulation

**Decision rationale:** Since there is no medical necessity for the requested Avid interferential muscle stimulator, there is no demonstrated medical necessity for the purchase of the interferential muscle stimulator supplies.