

<b>Case Number:</b>	CM14-0149418		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	01/04/2010
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	08/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/15/2014

### 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 Louisiana. 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 54 year old male who was injured on 01/04/2010 while draining a drainage pipe sustaining an injury to his back and knees. First doctor report dated 07/11/2014 documented the patient to have complaints of right shoulder pain and low back pain, rated as an 8/10 with associated tingling sensations of the left foot. Objective findings on exam revealed tenderness over the lumbar paraspinal muscles on the left side. There was limited range of motion due to pain and positive straight leg raise at 70 degrees. He had positive Apply's scratch test and hypoesthesia at C6 and C7 of the right dermatome. The patient was diagnosed with lumbar radiculopathy, left sciatica, left foot drop and right shoulder sprain/strain. The patient was recommended for an Interspec IF II with monthly supplies, cold therapy unit and one assay strap. Prior utilization review dated 08/18/2014 states the request for Unknown Interspec IF II and monthly supplies; 1 Cold therapy unit; and 1 assay strap is recommended non-certified as medical necessity has not been established.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Unknown Interspec IF II and monthly supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

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

**Decision rationale:** Evidence based guidelines state that Interferential Current Stimulation is not recommended as an isolated intervention. The therapy may be appreciate if the pain is ineffectively controlled due to diminished effectiveness of medication or side effects of medications, there is a history of substance abuse, there is significant pain from postoperative conditions that limits the ability to perform exercise, or if the patient is unresponsive to conservative measures. If appropriate, a month trial may be indicated. There is no supporting documentation of ineffective medication, substance abuse, post-operative conditions, or unresponsive to conservative treatment as the guidelines states are necessary to warrant the use of Interferential Current Stimulation therefore, it is not medically necessary.

**1 Cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203,Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous flow cryotherapy

**Decision rationale:** According to the American College of Occupational and Environmental Medicine guidelines state that at home applications of cold packs may be used before or after exercises and are as effective as those performed by a therapist. The Official Disability Guidelines state that continuous flow cryotherapy machines are recommended as post-surgical options, but not for surgical treatment. In this case, there is no supporting documentation that this kind of treatment will be beneficial; therefore, this is not medically necessary.

**Assay strap:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.bio-rad.com/en-us/prime-pcr-assays/gene/strap-human>

**Decision rationale:** The California Medical Treatment Utilization Schedule, Official Disability Guidelines, and National Guideline Clearing House failed to reveal any guidelines or scientific evidence to support the use of an assay strap. There is no supporting documentation or clear rationale to warrant the use of an assay strap and there is no guideline recommendation to support this treatment therefore, this is not medically necessary.