

<b>Case Number:</b>	CM14-0097373		
<b>Date Assigned:</b>	07/28/2014	<b>Date of Injury:</b>	02/19/2014
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	06/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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 67 years old male with an injury date on 02/19/2014. Based on the 06/06/2014 progress report provided by [REDACTED], the diagnoses are sprain/Strain lumbar and sprain/Strain Sacrum. According to this report, the patient complains of increasing low back pain and stiffness. The patient is currently working regular job duties. The patient continuous with anti-inflammatory, pain medication and heat/cold application as needed. The patient completed 12/12 PT with benefit. Spasm and tenderness was noted at the thoracolumbar spine and paravertebral musculature. Range of motion of the lumbar spine was restricted. There were no other significant findings noted on this report. The utilization review denied the request on 06/13/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 04/30/2014 to 06/06/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interferential stimulator, electrodes, leadwires, and batteries, for purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114, 118. Decision based on Non-MTUS Citation ODG, Interferential therapy.

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

**Decision rationale:** According to the 06/06/2014 report by [REDACTED] this patient presents with increasing low back pain and stiffness. The physician is requesting interferential stimulator; electrodes; lead wires; batteries, for purchase. The MTUS Guidelines page 118 to 120 states that interferential current stimulation is not recommended as an isolated intervention. Indications include ineffectively controlled pain with medications, history of substance abuse, post-operative pain or failure of conservative measures. MTUS also recommends trying the unit for one-month before a home unit is provided if indicated. In this case, the patient does not present with a specific indication for IF unit and has not trialed the unit for a month to determine effectiveness. Therefore the request is not medically necessary.