

<b>Case Number:</b>	CM15-0111511		
<b>Date Assigned:</b>	06/18/2015	<b>Date of Injury:</b>	12/17/2014
<b>Decision Date:</b>	07/22/2015	<b>UR Denial Date:</b>	05/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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 York  
 Certification(s)/Specialty: Anesthesiology

### 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 46 year old male who sustained an industrial injury on 12/17/2014. Current diagnoses include status post anterior/posterior L5-S1 fusion with persistent pain with multilevel disc bulge and bilateral neuroforaminal stenosis L3-L4. Previous treatments included medication management and back surgery on 04/01/2015. Report dated 04/20/2015 noted that the injured worker presented with complaints that included lumbar spine pain with lower extremity radiating pain, numbness, and tingling. Pain level was not included. Physical examination was positive for an antalgic gait and stiffness, surgical site is healing well with no signs of infection. The treatment plan included request for pain management and psychiatric/psychologist consultation for evaluation and treatment, and prescribed Norco. Disputed treatments include IF unit with garment - 2 month rental, power packs #12 - 1 month supply, electrodes packs #4 packs - 1 month supply, adhesive remover towel mint #16, and functional capacity evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**IF Unit with garment - 2 month rental:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Interferential Therapy.

**Decision rationale:** According to MTUS, Interferential Current Stimulation (ICS) 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. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. This therapy is possibly appropriate for: pain ineffectively controlled due to diminished effectiveness of medications, significant pain from post-operative conditions limiting the ability to perform exercise programs or physical therapy (PT), or unresponsive to conservative treatment. The process involves paired electrodes of two independent circuits carrying differing medium frequency alternating currents so that current flowing between each pair intersects at the underlying target. ICS works in a similar fashion as TENS, but at a substantially higher frequency (4000-4200 Hz). In this case, there is no indication that the post-operative medications were not controlling post-operative pain. In addition, there is no documentation of inability to perform the exercise program or PT. Medical necessity for the requested unit with garment has not been established. The requested unit is not medically necessary.

**Power Packs #12 - 1 month supply:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ICS Page(s): 120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Interferential Therapy.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Electrodes Packs #4 packs - 1 month supply:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ICS Page(s): 120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Interferential Therapy.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Adhesive Remover Towel Mint #16 - 1 month supply:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Interferential Therapy.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Functional Capacity Evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter, Functional Capacity Evaluation (FCE).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Capacity Evaluation (FCE) Page(s): 48.

**Decision rationale:** The CA MTUS states that a functional capacity evaluation (FCE) is recommended under certain specific circumstances. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. It should include work functions and or activities of daily living, self-report of disability, objective measures of the patient's functional performance and physical impairments. The guidelines necessitate documentation indicating case management is hampered by complex issues (prior unsuccessful return to work attempts, conflicting medical reports on precautions and/or fitness for modified job), injuries that require detailed exploration of a worker's abilities and clarification of all additional/secondary conditions in order to recommend an FCE. In this case, there is no documentation of the patient's ability secondary to shoulder dysfunction. There is no information available to indicate the necessity for an FCE in regards to the patient's condition and work capabilities. Medical necessity for the requested service has not been established. The requested service is not medically necessary.