

<b>Case Number:</b>	CM15-0118707		
<b>Date Assigned:</b>	06/29/2015	<b>Date of Injury:</b>	07/24/2001
<b>Decision Date:</b>	07/29/2015	<b>UR Denial Date:</b>	06/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/19/2015

### 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: Texas, California  
 Certification(s)/Specialty: Family Practice

### 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 53 year old female, who sustained an industrial injury on July 24, 2001, incurring low back injuries. She was diagnosed with lumbar disc disease, and lumbar spondylolisthesis. Treatment included physical therapy, pain medications, walker for mobility, lumbar brace, homecare and work modifications and restrictions. She underwent a lumbosacral anterior-posterior fusion in September, 2014. In October, 2014, the injured worker needed assistance with all activities; she had limited mobility, weakness, poor balance and difficulty with ambulation. She rated her pain 10 out of 10. Currently on 5/11/15, the injured worker complained of pain and numbness in the left buttock radiating down into the lower extremities. She complained of lower back pain associated with bending, stooping and lifting. The physical examination of the low back revealed negative SLR, no major motor deficits and normal sensory examination. The patient has used a TENS unit. Patient has received an unspecified number of PT visits for this injury. The treatment plan that was requested for authorization included durable medical equipment; one interferential unit, 12 electrodes, 12 batteries, and 1 low back garment. Patient has received an unspecified number of PT visits for this injury. The patient has had X-ray of the low back that revealed solid fusion. The patient has had MRI of the 6/4/14 that revealed foraminal narrowing, and post operative changes. The medication list include Tylenol #3 and Celebrex.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Durable medical equipment: IF unit, 12 electrodes, 12 batteries, 1 low back garment (3 month request) for the back:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page 118-120 Interferential Current Stimulation (ICS).

**Decision rationale:** Request: Durable medical equipment: IF unit, 12 electrodes, 12 batteries, 1 low back garment (3 month request. Per the CA MTUS Chronic Pain Medical Treatment Guidelines, 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. Per the cited guideline while not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: 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. Per the records provided, any indication listed above is not specified in the records provided. The records provided do not specify a response to conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts for this injury. Patient has received an unspecified number of PT visits for this injury. The records submitted contain no accompanying current PT evaluation for this patient. Detailed response to previous conservative therapy was not specified in the records provided. The previous PT visit notes are not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications is not specified in the records provided. The medical necessity of the request for Durable medical equipment: IF unit, 12 electrodes, 12 batteries, 1 low back garment (3 month request is not fully established in this patient.