

<b>Case Number:</b>	CM15-0064387		
<b>Date Assigned:</b>	04/10/2015	<b>Date of Injury:</b>	07/18/2002
<b>Decision Date:</b>	05/13/2015	<b>UR Denial Date:</b>	03/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/06/2015

### 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:

This is a 60 year old female patient, who sustained an industrial injury on July 18, 2002. The diagnoses include cervical syndrome with radiculopathy, status post microdecompressive endoscopic discectomy of C4 and C5 with laser thermocoagulation 09/16/02 and status post lumbar microdecompressive endoscopic discectomy of L4-L5 with laser thermocoagulation 09/09/02. Per the note dated 4/21/2010, she had cervical pain with radiculitis and low back pain with sciatica. Physical examination of the cervical spine revealed tenderness to palpation and decreased range of motion. Examination of the lumbosacral spine revealed decreased range of motion, tenderness to palpation and positive straight leg raise. Per the previous utilization review, on the 3/16/2015, she had complaints of lumbar pain. The physical examination revealed pain to the lumbar spine and decreased strength and motion of the lumbar spine. The medications list includes norco. She has undergone microdecompressive endoscopic discectomy of C4 and C5 with laser thermocoagulation 09/16/02 and lumbar microdecompressive endoscopic discectomy of L4-L5 with laser thermocoagulation 09/09/02. She has had physical therapy and nerve block injections for this injury.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**30 Day rental of an Interferential unit with supplies for lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential stimulation.

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

**Decision rationale:** Request: 30 Day rental of an Interferential unit with supplies for lumbar spine; 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. There is no evidence of failure of conservative measures like physical therapy or pharmacotherapy for this patient. Any evidence of diminished effectiveness of medications or intolerance to medications or history of substance abuse is not specified in the records provided. The medical necessity of 30 Day rental of an Interferential unit with supplies for lumbar spine is not fully established for this patient at this juncture. Therefore, the requested medical treatment is not medically necessary.

**60 Day rental of an Interferential unit with supplies for lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential stimulation.

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

**Decision rationale:** Request: 60 Day rental of an Interferential unit with supplies for lumbar spine; 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. There is no evidence of failure of conservative measures like physical therapy or pharmacotherapy for this patient. Any evidence of diminished effectiveness of medications or intolerance to medications or history of substance abuse is not specified in the records provided. The medical necessity of 60 Day rental of an Interferential unit with supplies for lumbar spine is not fully established for this patient at this juncture. Therefore, the requested medical treatment is not medically necessary.

**Purchase of an Interferential unit with supplies for lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential stimulation.

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

**Decision rationale:** Request: Purchase of an Interferential unit with supplies for lumbar spine; 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). There is no evidence of failure of conservative measures like physical therapy or pharmacotherapy for this patient. Any evidence of diminished effectiveness of medications or intolerance to medications or history of substance abuse is not specified in the records provided. The medical necessity of Purchase of an Interferential unit with supplies for lumbar spine is not fully established for this patient at this juncture. Therefore, the requested medical treatment is not medically necessary.