

<b>Case Number:</b>	CM15-0071110		
<b>Date Assigned:</b>	04/21/2015	<b>Date of Injury:</b>	12/30/2009
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	03/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 48 year old male, who sustained an industrial injury on December 30, 2009. He has reported back pain, wrist pain, shoulder pain, arm pain, leg pain, ankle pain, knee pain, and foot pain. Diagnoses have included carpal tunnel syndrome, cervical spine intervertebral disc disorder, lumbar spine intervertebral disc disorder, and rotator cuff syndrome. Treatment to date has included medications, carpal tunnel release, imaging studies, and diagnostic testing. A progress note dated March 6, 2015 indicates a chief complaint of lower back pain, bilateral wrist pain, left shoulder pain, left arm pain, right leg pain, right knee pain, right ankle pain, right foot pain, right buttock pain, and anxiety. The treating physician documented a plan of care that included rental of an interferential unit and purchase of monthly supplies.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interspec Interferential II unit rental for two months:** Upheld

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

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

**Decision rationale:** Based on the 03/06/15 progress report provided by treating physician, the patient presents with lower back pain, bilateral wrist pain, left shoulder pain, left arm pain, right leg pain, right knee pain, right ankle pain, right foot pain, right buttock pain, and anxiety. The request is for interspec interferential II unit rental for two months. Patient's diagnosis per Request for Authorization form dated 03/19/15 includes carpal tunnel syndrome, wrist post-op, cervical and lumbar intervertebral disc disorder, and rotator cuff syndrome. Treatment to date has included carpal tunnel release, imaging, diagnostic testing, and medications. Patient medications include Norco and topical compound. The patient is temporarily totally disabled, per 03/06/15 treater report. MTUS pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: "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 03/06/15 progress report, treater states "Home interferential stimulator unit for chronic pain over 90 days. 60 days rental initial trial." Treater has not discussed reason for the request, nor how the device will be used, or what body part will be treated. Medical records show the requested treatment is not intended as an isolated intervention, as the patient takes Norco and physical therapy is planned. With regards to interferential unit, there is no evidence that pain is not effectively controlled due to the effectiveness of medication, substance abuse or pain due to postoperative conditions or unresponsiveness to conservative measures. Per 03/06/15 progress report, treater states, "the patient feels better with pain medication, rest and topical compound," which shows patient is still responsive to conservative measures. Furthermore, IF unit is indicated for a one-month trial, and the request is for 60 days. This request is not in accordance with guideline recommendations. Therefore, the request for 2 month interferential unit rental IS NOT medically necessary.

**Monthly supplies purchase:** Upheld

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

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

**Decision rationale:** Based on the 03/06/15 progress report provided by treating physician, the patient presents with lower back pain, bilateral wrist pain, left shoulder pain, left arm pain, right

leg pain, right knee pain, right ankle pain, right foot pain, right buttock pain, and anxiety. The request is for monthly supplies purchase. Patient's diagnosis per Request for Authorization form dated 03/19/15 includes carpal tunnel syndrome, wrist post-op, cervical and lumbar intervertebral disc disorder, and rotator cuff syndrome. Treatment to date has included carpal tunnel release, imaging, diagnostic testing, and medications. Patient medications include Norco and topical compound. The patient is temporarily totally disabled, per 03/06/15 treater report. MTUS pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: "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 03/06/15 progress report, treater states "Home interferential stimulator unit for chronic pain over 90 days. 60 days rental initial trial." Treater has not discussed reason for the request, nor how the device will be used, or what body part will be treated. Medical records show the requested treatment is not intended as an isolated intervention, as the patient takes Norco and physical therapy is planned. With regards to interferential unit, there is no evidence that pain is not effectively controlled due to the effectiveness of medication, substance abuse or pain due to postoperative conditions or unresponsiveness to conservative measures. Per 03/06/15 progress report, treater states "the patient feels better with pain medication, rest and topical compound," which shows patient is still responsive to conservative measures. Furthermore, IF unit is indicated for a one-month trial, and the request is for 60 days. The request for IF unit is not in accordance with guideline recommendations. Therefore, the request for two month IF unit supplies IS NOT medically necessary.