

<b>Case Number:</b>	CM13-0048018		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	02/26/2002
<b>Decision Date:</b>	03/11/2014	<b>UR Denial Date:</b>	10/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management has a subspecialty in Disability Evaluation and is licensed to practice in California, District of Columbia, Florida and Maryland. 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 physician 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 sustained an injury on 2/26/2002 to his right hand/neck/back as a result of driving over a pot hole. According to the medical records he was diagnosed with cervical strain/lumbar strain. Based on the medical report dated 7/8/13, the patient has undergone an MRI scan of the right shoulder on 6/26/13, which revealed acromioclavicular joint degenerative joint disease and subacromial impingement and tear of the superior labrum. The patient is advised that surgery is indicated. The patient reported pain level of 5 to 6 out of 10. On examination of the right shoulder, range of motion reveals 125 degrees forward flexion, 40 degrees extension, 125 degrees abduction, 40 degrees adduction, 60 degrees external rotation, and 90 degrees internal rotation. Severe tenderness is noted in the supraspinatus of the right shoulder. Moderate tenderness is noted in the greater tuberosity and acromioclavicular joint. Mild tenderness is noted in the biceps tendon. Subacromial crepitus is positive. Muscle strength and tone of the right shoulder decreased 4/5. Impingement test is positive. He is currently diagnosed with status post continuous trauma of the right upper extremity injury, with subacromial impingement syndrome, acromioclavicular degenerative joint disease and superior labral tear.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**The request for 1 leadwire:** 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 Stimulation Page(s): 121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Pain (Chronic) (Updated 1/7/2014) Interferential current stimulation (ICS).

**Decision rationale:** Based on the clinical information provided, the request for Leadwire is not recommended as medically necessary. The Chronic Pain Medical Treatment Guidelines and ODG do not support approval of 1 leadwire. A concurrent request for interferential unit rental has been documented that pain is ineffectively controlled due to diminished effectiveness of medications. Current evidence based guidelines note that interferential stimulation is not recommended as an isolated intervention. There is no indication that significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment as the patient has not undergone surgical intervention as of yet.

**The request for 1 tech fee:** 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 Stimulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Pain (Chronic) (Updated 1/7/2014) Interferential current stimulation (ICS).

**Decision rationale:** Based on the clinical information provided, the request 1 tech fee is not recommended as medically necessary. The Chronic Pain Medical Treatment Guidelines and ODG do not support approval of 1 tech fee. A concurrent request for interferential unit rental has been documented that pain is ineffectively controlled due to diminished effectiveness of medications. Current evidence based guidelines note that interferential stimulation is not recommended as an isolated intervention. There is no indication that significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment as the patient has not undergone surgical intervention as of yet. There are no specific time-limited treatment goals provided. Given that the inferential unit has not been approved, the request for supplies is not medically necessary.

**The request for 12 power packs:** 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 Stimulation Page(s): 121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Pain (Chronic) (Updated 1/7/2014) Interferential current stimulation (ICS).

**Decision rationale:** Based on the clinical information provided, the request for 112 power packs is not recommended as medically necessary. The Chronic Pain Medical Treatment Guidelines and ODG do not support approval of 112 power pack. A concurrent request for interferential unit rental has been documented that pain is ineffectively controlled due to diminished effectiveness of medications. Current evidence based guidelines note that interferential stimulation is not recommended as an isolated intervention. There is no indication that significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment as the patient has not undergone surgical intervention as of yet. There are no specific time-limited treatment goals provided. Given that the inferential unit has not been approved, the request for supplies is not medically necessary.

**The request for 16 adhesive removers, mint:** 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 Stimulation Page(s): 121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Pain (Chronic) (Updated 1/7/2014) Interferential current stimulation (ICS).

**Decision rationale:** Based on the clinical information provided, the request for 16 Adhesive Remover Towel Mint is not recommended as medically necessary. The Chronic Pain Medical Treatment Guidelines and ODG do not support approval of 16 adhesive removers, mint. A concurrent request for interferential unit rental has been documented that pain is ineffectively controlled due to diminished effectiveness of medications. Current evidence based guidelines note that interferential stimulation is not recommended as an isolated intervention. There is no indication that significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment as the patient has not undergone surgical intervention as of yet. There are no specific time-limited treatment goals provided. Given that the inferential unit has not been approved, the request for supplies is not medically necessary.