

<b>Case Number:</b>	CM14-0115635		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	02/13/2014
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	07/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management, and is licensed to practice in California. 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/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:

This is a 42-year-old male with a 2-13-2014 date of injury. A specific mechanism of injury was not described. On 7/9/14 determination found to be not medically necessary given that CA MTUS does not recommend electrical stimulation as an isolated therapeutic modality and that there is no documentation of derived functional improvement from any previous use of electrical stimulation under the supervision of a licensed physical therapist. A 7/2/14 medical report identified improving pain in the left shoulder, left wrist, and lumbar spine. Exam revealed tenderness, spasms, limited ROM of the lumbar spine, tenderness in the left wrist, left shoulder, and positive impingement test. Diagnoses include cervical sprain/strain, tendinitis of left shoulder, left wrist sprain/strain, and lumbar sprain/strain. Treatment to date had included activity modification, medications, and physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**IF Unit for Home:** 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 Page(s): 118-120.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation 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 was no clear indication for the necessity of the requested IF unit despite no support for its use by CA MTUS. There appears to be improvement in the patient's symptoms and the provided note did not describe the need for the unit. There were also no goals to attain from the use of such unit or any indication that the patient had use it successfully in the therapy sessions. There was insufficient documentation to support this request.