

<b>Case Number:</b>	CM14-0122002		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	11/29/2010
<b>Decision Date:</b>	11/24/2014	<b>UR Denial Date:</b>	07/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/01/2014

### 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 Medicine 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 patient with a date of injury of October 21, 2013. A utilization review determination dated July 24, 2014 recommends non-certification for interferential supplies. A progress report dated August 19, 2014 identifies subjective complaints of low back pain, right shoulder pain, and middle finger pain. The patient has attended physical therapy and tried medications which are provided only temporary relief. The patient was prescribed a home tens unit which she uses on a regular basis. Current complaints include right shoulder pain radiating to the right fingers and hand. The patient also complains of low back pain. Physical examination findings reveal tenderness to palpation over the right shoulder, positive cross body abduction test and decreased range of motion in the lumbar spine. Diagnoses include a right shoulder strain; right long finger strain, lumbar strain, and chronic pain syndrome. The treatment plan recommends medication, cognitive behavioral therapy, and counseling regarding chronic pain issues of sleep and diet.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Durable Medical Equipment (DME) -Interferential Unit, Electrode, & Batteries- 2 Months:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 118-120.

**Decision rationale:** Regarding the request for interferential unit and supplies, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested interferential unit and supplies are not medically necessary.