

<b>Case Number:</b>	CM14-0070898		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	08/29/2009
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	04/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/16/2014

### 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 and is licensed to practice in Nevada. 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:

The records, presented for review, indicate that this 76-year-old gentleman was reportedly injured on August 29, 2009. The most recent progress note, dated February 13, 2014, indicated that there were ongoing complaints of right and left shoulder pains. The physical examination demonstrated tenderness over the left shoulder and subacromial area. There were weakness and pain with resistance to forward flexion and external rotation as well as a positive impingement sign. There was a diagnosis of left shoulder tendinopathy. Additional physical therapy was recommended. Diagnostic imaging studies were not reviewed during this visit. Previous treatment included a right shoulder reverse replacement, physical therapy, and home exercise. A request had been made for the purchase of an inferential stimulator with one year of supplies and a hot/cold pack with wrap and was not certified in the pre-authorization process on April 11, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Purchase of Interferential stimulator with one year of supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulator (ICS).

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

**Decision rationale:** According to the California Chronic Pain Medical Treatment Guidelines, the criteria for the use of an inferential stimulator includes that pain is ineffectively controlled due to diminished effectiveness of medications or their side effects. Additionally, the injured employee should be documented as being unresponsive to conservative measures. A review of the medical records does not indicate that the injured employee meets these criteria. As such, this request for the purchase of an inferential stimulator and one year of supplies is not medically necessary.

**Hot and cold pack with wrap:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation, Shoulder Procedure Summary

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Cold Compression Therapy

**Decision rationale:** According to the Official Disability Guidelines, use of cold compression therapy is not recommended in the shoulder as there are no published studies to demonstrate its efficacy. Considering this, the request for a hot/cold pack with wrap is not medically necessary.