

<b>Case Number:</b>	CM14-0072068		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	07/06/2009
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	04/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/19/2014

### 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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 54-year-old male who reported an injury on 07/06/2009. The mechanism of injury was not provided. On 08/26/2013, the injured worker presented with pain over the posterolateral right shoulder and neck pain. Upon examination of the right shoulder, there was full forward flexion and some pain with good strength to the supraspinatus. There is tenderness over the biceps with some tenderness over the impingement area and lateral bursa. There were 2+ positive impingement 1 and 2 findings. The diagnoses were status post medial meniscectomy and chondroplasty of the left knee, status post incision of the osteochondroma and partial ostectomy, left proximal tibia, chronic pain to the right lower extremity, and right shoulder pain with positive rotator cuff pathology. Prior therapy included exercise, stretching, and strengthening with a Theraband and ice. The provider recommended a stimulation unit, 3 months' worth of supplies purchase, 9 pack electrodes and 9 packs gel; the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Stimulation Unit 3 Months' worth supplies purchase (9 Pack Electrodes and 9 Packs Gel):**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

**Decision rationale:** The request for a stimulation unit, 3 months' worth supplies purchase, 9 pack electrodes and 9 packs gel is not medical necessary. The California MTUS does not recommend a stim care unit as an isolated intervention. There is no quality evidence of effectiveness, except in conjunction with recommended treatments including return to work, exercise, and medications. It may be recommended if pain is ineffectively controlled by medication, medication intolerance, history of substance abuse, significant pain from postoperative conditions which limits the ability to perform exercise programs or physical therapy treatment, or unresponsiveness to conservative measures. A 1-month trial may be appropriate to permit the provider to study the effects and benefits of the stimulation therapy unit. The provider's request for a stimulation unit, 3 months' worth of supplies purchase, 9 pack electrodes and 9 packs gel exceeds the recommendations of the guideline. The included documentation does not indicate that the injured worker participated in an adequate trial to determine the efficacy of the stimulation unit therapy. Additionally, the provider's request did not indicate the site that the stimulation unit is intended for in the request as submitted. As such, the request is not medically necessary.