

<b>Case Number:</b>	CM15-0136689		
<b>Date Assigned:</b>	07/24/2015	<b>Date of Injury:</b>	09/01/2009
<b>Decision Date:</b>	08/21/2015	<b>UR Denial Date:</b>	06/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Emergency Medicine

### 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 66 year old female who sustained an industrial injury on 9/1/09 when she fell from a ladder injuring her left ankle and right shoulder. She has had surgery on the left ankle, Achilles and right shoulder. She currently reports improvement with left foot and ankle but still with limited range of motion; left shoulder pain from over compensation; right wrist pain. Her pain level was 6/10. X-rays were done and reveal no increase in osteoarthritis. She has difficulty with activities of daily living including hygiene. Medications were not specifically identified but in the 6/12/15 note the treating provider ordered Norco. Diagnoses include left ankle sprain/ strain, status post left ankle surgery (11/11/2010); rotator cuff tear right shoulder with rupture of biceps, felt to be a consequence of positioning at the time of her ankle surgery; sprain/ strain of the cervical spine, probable cervical radiculopathy; sprain/ strain of the lumbar spine; anterior lateral ankle instability, status post repair (6/2013); right shoulder subacromial decompression with distal clavicle resection arthroscopically (12/12/12); left ankle surgery, open ankle repair with modified Brostrom procedure, partial lateral meniscectomy, removal of loose body and peroneal tendon tenosynovectomy. Treatments to date include physical therapy to the left ankle; medications. Diagnostics include MRI of the lumbar spine (5/18/15) showing disc protrusion, disc bulge; MRI of the cervical spine (5/18/15) showing disc bulging, mild disc space narrowing; MRI of the right shoulder (5/11/15) showing complete tear of the supraspinatus tendon, partial tear of the subscapularis tendon, complete tear of the biceps tendon, small joint effusion, degenerative changes; electrodiagnostic study (5/1/15) showing normal results. In the progress note dated 6/12/15 the treating provider's plan of care includes a request for an interferential unit for 30-60 day rental and purchase if effective for long term care with supplies as needed to manage pain and reduce medication usage.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**(IF) Interferential unit/supplies 30-60 day rental, purchase it effective:** 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 CA Transcutaneous electrotherapy, Interferential current stimulation Page(s): 118-120.

**Decision rationale:** The requested (IF) Interferential unit/supplies 30-60-day rental, purchase it effective, is not medically necessary. CA Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy, Interferential current stimulation, Page 118-120, noted that this treatment 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 are no published randomized trials comparing TENS to Interferential current stimulation;" and the criteria for its use are: "Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.)." The injured worker reports improvement with left foot and ankle but still with limited range of motion; left shoulder pain from over compensation; right wrist pain. Her pain level was 6/10. X-rays were done and reveal no increase in osteoarthritis. The treating physician has not documented any of the criteria noted above, nor a current functional rehabilitation treatment program, nor derived functional improvement from electrical stimulation including under the supervision of a licensed physical therapist. The criteria noted above not having been met, (IF) Interferential unit/supplies 30-60 day rental, purchase it effective is not medically necessary.