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| <b>Case Number:</b>   | CM15-0194374 |                              |            |
| <b>Date Assigned:</b> | 10/08/2015   | <b>Date of Injury:</b>       | 09/17/2013 |
| <b>Decision Date:</b> | 11/16/2015   | <b>UR Denial Date:</b>       | 09/28/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/02/2015 |

### 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: Physical Medicine & Rehabilitation

### 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 60 year old male, who sustained an industrial injury on 09-17-2013. He has reported injury to the left shoulder and low back. The diagnoses have included bilateral shoulder tendinopathy with impingement and cervical strain; left shoulder high-grade partial-thickness rotator cuff tear; status post left shoulder rotator cuff repair, on 04-29-2015; and lumbar radiculopathy with L2-L3 and L3-L4 central stenosis. Treatment to date has included medications, diagnostics, lumbar support, physical therapy, home exercise program, and surgical intervention. Medications have included Norco. A progress report from the treating provider, dated 03-02-2015, documented an evaluation with the injured worker. The injured worker reported continued low back pain that radiates into the low back at times; continued left shoulder pain that substantially impaired his ability to perform daily activities; the left shoulder symptoms are his primary complaint at this time, but he does also have some pain and stiffness involving his right shoulder; and episodic right-sided neck spasms that can severely impair his neck range of motion. Objective findings included attenuated left shoulder range of motion is present with considerable crepitation with shoulder motion; moderate weakness principally with abduction and flexion of the left shoulder versus that of the right is evident; moderate right-side cervical tenderness is maximal over the C3-C5 with some spasm and muscle guarding; present; and examination of the low back is unchanged. A progress note from another provider, dated 04-15-2015, documented an evaluation with the injured worker. The injured worker reported that his back continued to bother him daily; and the pain radiates to the buttocks, but not beyond that into the thigh. Examination of the spine revealed he has tenderness and some evidence of spasm especially in the right paralumbar area; and active voluntary range of motion of the thoracolumbar spine was limited. The treatment plan has included the request for DME (Durable Medical

Equipment): IF (Interferential) unit. The original utilization review, dated 09-28-2015, non-certified the request for DME (Durable Medical Equipment): IF (Interferential) unit.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**DME: IF (interferential) unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

**Decision rationale:** The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage, increased pain relief or improved functional status derived from any transcutaneous electrotherapy to warrant a purchase of an interferential unit for home use for this chronic 2013 injury. Additionally, IF unit may be used in conjunction to a functional restoration process with improved work status and exercises not demonstrated here. The DME: IF (interferential) unit is not medically necessary and appropriate.