

<b>Case Number:</b>	CM15-0195676		
<b>Date Assigned:</b>	10/09/2015	<b>Date of Injury:</b>	08/05/2014
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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 48 year old female, who sustained an industrial injury on 08-05-2014. The injured worker is currently temporarily totally disabled. Medical records indicated that the injured worker is undergoing treatment for right shoulder rotator cuff tear and rule out right carpal tunnel syndrome. Treatment and diagnostics to date has included rights shoulder surgery (dated 09-15-2015). Recent medications have included Norco and Diclofenac. After review of progress notes dated 07-28-2015 and 09-01-2015, the injured worker reported right shoulder pain (rated 6 out of 10 on the pain scale) and right wrist pain (rated 7 out of 10). Objective findings included right shoulder weakness with range of motion, positive right shoulder drop arm, impingement, and Hawkins-Kennedy impingement tests, positive right sided hand-wrist Durkan's median compression test, and diminished light touch in the right median nerve distribution. The Utilization Review with a decision date of 09-17-2015 non-certified the request for IF (interferential) unit and supplies (rental or purchase).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**IF unit and supplies (rental or purchase): Upheld**

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

**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 rental or purchase of an interferential unit for home use for this chronic August 2014 injury. Additionally, IF unit may be used in conjunction to a functional restoration process with improved work status and exercises not demonstrated here. The IF unit and supplies (rental or purchase) is not medically necessary and appropriate.