

<b>Case Number:</b>	CM15-0202786		
<b>Date Assigned:</b>	10/19/2015	<b>Date of Injury:</b>	12/28/2014
<b>Decision Date:</b>	11/30/2015	<b>UR Denial Date:</b>	10/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2015

### 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: Arizona, California  
 Certification(s)/Specialty: Family Practice

### 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 53 year old female who sustained an industrial injury on 12-28-2014. A review of medical records indicates the injured worker is being treated for right shoulder pain, right elbow pain, and right wrist-hand pain with numbness and tingling. Medical records dated 7-22-2015 noted right shoulder pain, right elbow pain, and right wrist and hand pain. Physical examination noted tenderness over the right shoulder. Range of motion was restricted. There was tenderness over the medial and lateral epicondyles. Range of motion was restricted. There was tenderness over the right wrist. Treatment has included conservative measures. Utilization review form noncertified home interferential unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home Interferential unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** According to the guidelines an IF unit 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. In this case, the claimant was offered therapeutic ultrasound, acupuncture and an IF unit. There is no indication for multiple modalities. Length and frequency of use was not specified. The request for an IF unit is not a medical necessity for elbow and shoulder pain.