

<b>Case Number:</b>	CM15-0056063		
<b>Date Assigned:</b>	04/01/2015	<b>Date of Injury:</b>	07/15/2009
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2015

### 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 female, who sustained an industrial injury on July 15, 2009. The injured worker was diagnosed as having shoulder peri-arthritis, shoulder tendinitis, lumbar intervertebral disc displacement without myelopathy, and cervical intervertebral disc displacement without myelopathy. She is status post left shoulder arthroscopy and tenosynovectomy, left shoulder acromioplasty and partial coracoacromial ligament release, and left shoulder manipulation under anesthesia on July 29, 2014. Treatment to date has included physical therapy. On February 2, 2015, the injured worker complains of left cervical, left cervical dorsal, left anterior and posterior shoulder, and left posterior arm pain. Associated symptoms include numbness and tingling of the anterior left anterior shoulder, arm, elbow, wrist, and hand. Physical therapy, home exercise, and rest help her feel better. The physical exam revealed decreased range of motion of the shoulder and decreased motor strength. The treatment plan includes a home inferential stimulator unit for chronic pain over 90 days.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home interferential stimulator unit x 90 days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
interferential current unit Page(s): 118.

**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. While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine. Pain is ineffectively controlled due to diminished effectiveness of medications. Pain is ineffectively controlled with medications due to side effects. History of substance abuse. Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment. Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). In this case, there is no indication of medicine failure. The claimant does respond to therapy, exercise and rest. The request for a 9- day use of IF unit is not medically necessary.