

<b>Case Number:</b>	CM15-0084528		
<b>Date Assigned:</b>	05/06/2015	<b>Date of Injury:</b>	08/25/2009
<b>Decision Date:</b>	06/09/2015	<b>UR Denial Date:</b>	04/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/02/2015

### 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: Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 59 year old female, who sustained an industrial injury on 8/25/10. She reported pain in both shoulders. The injured worker was diagnosed as having a right shoulder rotator cuff tear and bilateral shoulder tendinosis and bursitis. Treatment to date has included physical therapy, Tramadol and Vicodin. As of the PR2 dated 4/8/15, the injured worker reports 7/10 pain in her right shoulder. The treating physician noted upper arm tenderness and limited range of motion to the shoulder. The plan was for right shoulder tendon repair and acromioplasty with utilization of post operative clod therapy, pain pump, shoulder sling and interferential unit with supplies. The treating physician requested a rental of an IF unit and supplies; electrode, batteries, removers and lead wires. The medications listed are Norco, diclofenac, pantoprazole and cyclobenzaprine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Rental of IR unit and supplies; electrodes, batteries, removers and lead wires:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ICS Page(s): 120.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211, Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 114-116, 118. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Shoulders.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that interferential units can be utilized as a component of comprehensive return to work program. The efficacy of the utilization of interferential unit for the post operative management of shoulder conditions had not been established. There records indicate that the patient would be utilizing a cold therapy unit, shoulder sling and pain pump in the post operative period. The criteria for the utilization of the rental interferential unit with supplies- batteries, electrodes, removers and lead wires were not met. The request is not medically necessary.