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| <b>Case Number:</b>   | CM14-0164550 |                              |            |
| <b>Date Assigned:</b> | 10/09/2014   | <b>Date of Injury:</b>       | 05/02/2012 |
| <b>Decision Date:</b> | 12/19/2014   | <b>UR Denial Date:</b>       | 09/22/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/07/2014 |

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 58 year old male with an injury date of 05/02/12. The most recent examination is contained in the Pain Management report of 07/21/14 that states that the patient presents with axial lower back pain mostly right sided along with right shoulder pain. The patient continues to work. Examination of the right shoulder shows tenderness over the superior border of trapezius muscle and acromioclavicular joint area. Further examination reveals tenderness in the lumbar spine over L4-L5, L5-S1 facet area mainly on the right with positive facet loading for pain in the lower lumbar region. The 09/11/14 right shoulder arthroscopy gives a post-operative diagnosis of Right shoulder impingement syndrome. The patient diagnoses from 07/21/14 include: 1. Lumbar spine sprain/strain 2. Axial lower back pain, more on the right side, rule out facet arthropathy 3. Right shoulder pain rule out impingement syndrome 4. MRI finding of labral tear, right shoulder. The utilization review being challenged is dated 07/22/14. Reports were provided from 03/26/14 to 07/29/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**The purchase of an Interferential Unit with Electrodes 4 per pack, batteries, set up and delivery.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118,120.

**Decision rationale:** The patient presents with right sided lower back pain and right shoulder pain. The treater requests for the purchase of an interferential unit with electrodes 4 per pack, batteries, set up and deliver. California Medical Treatment Utilization Schedule (MTUS) pages 118 to 120 states that Interferential Current Stimulation (ICS) are not recommended as an isolated intervention. MTUS further states, "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway." It may be appropriate if pain is not effectively controlled due to diminished effectiveness or side effects of medication; history of substance abuse, significant pain due to postoperative conditions; or the patient is unresponsive to conservative measures. A one month trial may be appropriate if the above criteria are met. The reports from 03/26/14 to 07/21/14 show that the requested treatment is not intended as an isolated intervention for the patient. The patient has received a regimen of medications and acupuncture treatment and the treater has requested for Functional Restoration visits, hot/cold therapy, deep vein thrombosis (DVT) therapy, ESWT, TENS, Shoulder Home exercise kits, and diagnostic facet blocks. It is not clear if the patient received these requested treatments as they are not further discussed in the reports provided. Pain is not routinely assessed through the use of pain scales so it is unclear if pain is controlled by medications. Pain is recorded as 5-8/10 on 04/08/14 and on 04/23/14 and 05/28/14 the treater states pain is well controlled by medication. There is no discussion of diminished effectiveness of medication due to side effects or a history of substance abuse. Two RFAs dated 03/28/14 and 07/30/14 are included for the IF unit purchase; however, the treater does not discuss the reason for the request. Since these requests, the patient underwent a right shoulder arthroscopy on 09/11/14; however, there is no evidence of significant post-operative pain. Furthermore, there is no evidence of a prior 30 day home trial of an IF unit as required by MTUS. Recommendation is not medically necessary and appropriate.