

<b>Case Number:</b>	CM15-0019107		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	08/10/2013
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/02/2015

### 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: 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 36-year-old male, with a reported date of injury of 08/10/2013. The diagnoses include anterior instability and impingement syndrome of the left shoulder; status post left shoulder arthroscopic repair; bursae and tendon disorder of the shoulder; and shoulder joint pain. Treatments have included an MR Arthrogram of the left shoulder on 08/25/2014; left shoulder arthroscopy with Bankart repair, acromioplasty, Mumford procedure, lysis of adhesions, subacromial bursectomy, partial synovectomy, removal of loose bodies, and insertion of a pain pump in the subacromial space on 12/1/2013; chiropractic treatment; a left shoulder arthroscopy on 01/05/2015; and an x-ray of the left shoulder showed no increase of osteoarthritis. The progress report dated 01/15/2015 indicates that the injured worker was seen for his initial post-operative examination of the left shoulder. He complained of left shoulder pain that radiated to the left elbow. He stated that his left shoulder was painful, and he takes the pain medication before bed. The injured worker rated his pain 9 out of 10. The objective findings include weakness in the internal and external rotation. The treating physician requested an interferential unit for 30-60 day rental and purchase if effective for long-term care with supplies as needed to manage pain and restore function. On 01/28/2015, Utilization Review (UR) denied the request for 30-60 day rental of an Interferential Unit and supplies with the purchase for long-term use if effective for the left shoulder, noting that there should be evidence of increased functional improvement, less reported pain, and evidence of medication reduction. The MTUS Chronic Pain Guidelines and the MTUS ACOEM Guidelines were cited.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**30-60 Day Rental of Interferential Unit and Supplies with Purchase for Long Term Use if Effective; Left Shoulder:** Upheld

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

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

**Decision rationale:** Per the 01/15/15 report the patient presents with left shoulder pain rated 9/10 radiating to the left elbow s/p left shoulder arthroscopy. The current request is for 30-60 DAY RENTAL OF INTERFERENTIAL UNIT AND SUPPLIES WITH PURCHASE FOR LONG TERM USE IF EFFECTIVE; LEFT SHOULDER per the 01/20/15 RFA and 01/15/15 report. The patient is to remain off work until 03/05/15. 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. In this case, this request is not an isolated intervention as physical therapy is requested. This unit is indicated for the patient's significant 9/10 postoperative pain. However, guidelines allow a trial of 30 days and this request is for 30-60 days. The request IS NOT medically necessary.