

<b>Case Number:</b>	CM15-0116768		
<b>Date Assigned:</b>	06/25/2015	<b>Date of Injury:</b>	10/23/2014
<b>Decision Date:</b>	07/23/2015	<b>UR Denial Date:</b>	05/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/17/2015

### 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 48 year old female who sustained an industrial injury on 10/23/14. Initial complaints and diagnoses are not available. Treatments to date include medications and physical therapy. Diagnostic studies include a MRI of the lumbar spine on 03/11/15 which showed degenerative disk and facet joint disease, as well as multiple bulging discs. An ultrasound of the bilateral shoulders on 04/08/15 showed a normal left shoulder, and right shoulder rotator cuff tendinitis, subacromial and subdeltoid bursitis, and acromioclavicular hypertrophy. Current complaints include left lower extremity radiculopathy and right shoulder pain. Current diagnoses include lumbar sprain/strain, right shoulder strain/impingement/subacromial and subdeltoid bursitis, acromioclavicular hypertrophy, and stress/anxiety/sleep/headaches. In a progress note dated 05/19/15 the treating provider reports the plan of care as a psychiatric consultation, an interferential unit for home use, and a subacromial injection under ultrasound guidance. The requested treatments include an interferential unit for home use, and a subacromial injection under ultrasound guidance.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interferential home unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential Current Stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines IF 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. 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, there is no mention of conjunctive treatments involving exercise. Indefinite use of an IF unit is not indicated. Therefore the purchase of a home IF unit is not medically necessary.

**Right shoulder SA joint injection under ultrasound guidance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Steroid injection, Criteria for Steroid injections.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 15 Stress Related Conditions Page(s): 213.

**Decision rationale:** According to the guidelines, 2-3 injections for the SA are recommended for rotator cuff inflammation, impingement and small tears. Frequent injections are not recommended. In this case, the claimant did have impingement findings on exam and a shoulder SA injection would be warranted for pain relief; however, there is no justification to perform this procedure under ultrasound. As a result, the request for the ultrasound guided SA injection is not medically necessary.