

Case Number:	CM15-0122901		
Date Assigned:	07/07/2015	Date of Injury:	07/15/2014
Decision Date:	08/07/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	06/25/2015

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: Connecticut, California, Virginia
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 37 year old male, who sustained an industrial injury on 07/15/2014. The injured worker reported prior injury that occurred on 07/07/2014 while the injured worker was pushing racks with wheels with equipment weighing up to 900 pounds causing a popping sensation to the injured worker's right shoulder. On 07/15/2015, the injured worker returned to work performing his usual work activities, noting symptoms with significantly increased pain to the right shoulder to the front of the chest. The injured worker also reported a popping sensation to the right shoulder with increased swelling, bruising, and difficulty raising his arm with the bruising increasing to the right wrist, with another popping sensation to the right shoulder that caused the injured worker fall down to the right landing on his right wrist. The injured worker was diagnosed as having left shoulder periscapular strain, right wrist injury/strain, status post right shoulder/right pectoralis tear/repair with resultant impingement, bursitis, and tendinitis. Treatment and diagnostic studies to date has included x-rays of the right shoulder, x-rays of the left shoulder, exercises, above noted procedure, and physical therapy. In a progress note dated 05/18/2015 the treating physician reports complaints of pain to the left shoulder, the right forearm/wrist, and to the right shoulder with weakness. Examination reveals tenderness to the right anterior deltoid and pectoralis major muscles, tenderness with spasm and muscle guarding to the upper trapezius and periscapular muscles on the left, tenderness to the dorsal aspect of the right wrist, subacromial crepitus to the right side, positive impingement test, positive cross arm test, positive apprehension test, and positive Yergason's test on the right side, and decreased range of motion to the right shoulder. The treating physician requested a one month rental home

interferential unit/electrical muscle stimulator with the treating physician noting goals of decreasing pain and spasm, improving range of motion, and to avoid prescription medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home interferential unit/electrical muscle stimulator, 1 month rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential current stimulation (ICS) Page(s): 114, 120.

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

Decision rationale: The MTUS guidelines do not recommend interferential current stimulation (ICS) as an isolated intervention. There are no standardized protocols for the use of interferential therapy, and the evidence does not support clear value to treatment, and while not recommended as an isolated intervention, patients should be selected for consideration only by meeting the following criteria: pain ineffectively controlled due to diminished effectiveness of medications or pain is ineffectively controlled with medications due to side effects. Additional criteria may include history of substance abuse or significant pain from postoperative conditions limiting the ability to perform exercise programs/physical therapy treatment, or unresponsiveness to conservative measures (repositioning, heat/ice, etc.). If the aforementioned criteria are met, consideration of a one-month trial may be appropriate to assess added benefit of treatment. The provided records do not discuss the criteria that would support consideration of ICS therapy (including conservative modalities like medications), and therefore given the provided records, the request cannot be considered medically necessary.