

<b>Case Number:</b>	CM15-0129936		
<b>Date Assigned:</b>	07/16/2015	<b>Date of Injury:</b>	09/12/2014
<b>Decision Date:</b>	08/12/2015	<b>UR Denial Date:</b>	06/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/06/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 30 year old female, who sustained an industrial injury on September 12, 2014. She reported pain in her head, bilateral shoulders, right wrist and both feet. The injured worker was diagnosed as having emotional headache, post-traumatic headache, cervical muscle spasm, cervical sprain/strain, thoracic sprain/strain, lumbar sprain/strain, right shoulder sprain/strain, left shoulder sprain/strain and right wrist sprain/strain. Treatment to date has included diagnostic studies, physical therapy, chiropractic care, acupuncture, water aerobics, exercise and medications. On May 26, 2015, the injured worker complained of lumbar spine pain rated as a 7 on a 1-10 pain scale, right shoulder pain rated as a 2/10 and left shoulder pain rated as a 2/10. The treatment plan included medications. A prior course of six to ten physical therapy was noted to improve symptoms to the bilateral shoulders, right wrist and low back. On June 2, 2015, Utilization Review non-certified the request for Interspec interferential stimulator purchase and monthly supplies purchase, citing evidence based guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interspec IF Stimulator (purchase), QTY: 1.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit (transcutaneous electrical nerve stimulation).

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

**Decision rationale:** The claimant sustained a work-related injury in September 2014 bil shoulder, right wrist, and low back pain. When seen, there was decreased and painful cervical and lumbar spine range of motion with tenderness and muscle spasms. There was decreased and painful shoulder range of motion with acromioclavicular joint tenderness and positive supraspinatus press testing bilaterally. Criteria for continued use of an interferential stimulation unit include evidence of increased functional improvement, less reported pain and evidence of medication reduction during a one-month trial. In this case, the claimant has not undergone a trial of interferential stimulation and purchase of a home interferential unit with supplies is not medically necessary.

**Monthly supplies (purchase) QTY: 1.00:** Upheld

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

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

**Decision rationale:** The claimant sustained a work-related injury in September 2014 bil shoulder, right wrist, and low back pain. When seen, there was decreased and painful cervical and lumbar spine range of motion with tenderness and muscle spasms. There was decreased and painful shoulder range of motion with acromioclavicular joint tenderness and positive supraspinatus press testing bilaterally. Criteria for continued use of an interferential stimulation unit include evidence of increased functional improvement, less reported pain and evidence of medication reduction during a one month trial. In this case, the claimant has not undergone a trial of interferential stimulation and purchase of a home interferential unit with supplies is not medically necessary.