

<b>Case Number:</b>	CM15-0028519		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	07/07/2013
<b>Decision Date:</b>	04/03/2015	<b>UR Denial Date:</b>	02/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2015

### 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: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

### 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 69 year old male, who sustained an industrial injury on July 7, 2013. He has reported pain in the neck, back, shoulders and left hand. The diagnoses have included cervical sprain/strain, shoulder sprain/strain, left hand sprain/strain, DeQuervain's left thumb and lumbar spine sprain, strain. Treatment to date has included radiographic imaging, diagnostic studies, conservative therapies, pain medications and work duty modifications. Currently, the IW complains of neck, back, shoulders and left hand. The injured worker reported an industrial injury in 2013, resulting in the above noted pain. He has been treated conservatively without a resolution of the pain. He reported slipping over a concrete block and landing on the right shoulder. He reported left shoulder and upper extremity pain secondary to compensatory techniques used to protect the right shoulder. Evaluation on May 6, 2014, revealed continued pain following 24 physical therapy treatments and the use of Tylenol for pain. He reported gastrointestinal upset with the use of nonsteroidal anti-inflammatories. On February 3, 2015, Utilization Review non-certified a request for IF unit x 5 month rental, noting the MTUS, ACOEM Guidelines, (or ODG) was cited. On February 10, 2015, the injured worker submitted an application for IMR for review of requested IF unit x 5 month rental.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Interferential unit 5 month rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120.

**Decision rationale:** ACOEM guidelines state "Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists." MTUS further states regarding interferential units, "Not recommended as an isolated intervention" and details the criteria for selection: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). "If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits." The available medical record does document a failure of physical therapy and medication in pain control meeting criteria, potentially, for a 1 month trial of IF therapy. There is no documentation of a one month trial or of evaluation post trial. As such the request for a 5 month rental of an interferential unit is deemed not medically necessary.