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|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM15-0056456 |                              |            |
| <b>Date Assigned:</b> | 04/01/2015   | <b>Date of Injury:</b>       | 09/11/2013 |
| <b>Decision Date:</b> | 05/06/2015   | <b>UR Denial Date:</b>       | 03/06/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/24/2015 |

### 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: New York, Tennessee  
 Certification(s)/Specialty: Emergency 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 53 year old male, who sustained an industrial injury on 09/11/2013. On provider visit dated 01/16/2015 the injured worker reported left shoulder pain. The diagnoses have included status post left shoulder rotator cuff repair. Treatment to date has included electrical stimulation, physical therapy, laboratory studies, medication and MRI. The provider requested interferential stimulator unit and supplies for left shoulder symptom management.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**IF unit supplies: Purchase of Electrode packs Qty: 4 packs, Power packs sty 12, Adhesive remover towel mint Qty: 16, Leadwire styl: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 118-119.

**Decision rationale:** Interferential current stimulation (ICS) 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. ICS is indicated when pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, there is a history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment, or the pain is unresponsive to conservative measures. In this case there is no indication that the patient has any of the above mentioned indications. Medical necessity has not been established. The request should not be authorized.