

<b>Case Number:</b>	CM15-0072259		
<b>Date Assigned:</b>	04/22/2015	<b>Date of Injury:</b>	03/30/2009
<b>Decision Date:</b>	05/20/2015	<b>UR Denial Date:</b>	04/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/16/2015

### 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 69 year old male injured worker suffered an industrial injury on 03/30/2009. The diagnoses included thoracic musculoligamentous strain/sprain, lumbar musculoligamentous strain/sprain with radiculopathy, lumbar discogenic disease, and bilateral shoulder strain/sprain. The diagnostics included left shoulder magnetic resonance imaging. The injured worker had been treated with medications. On 3/26/2015 the treating provider reported back pain, both shoulder pain and left groin pain. On exam there was thoracic, lumbar sacroiliac joint tenderness and spasms. The straight leg was positive. There was decreased muscle strength in the upper/ lower extremities. The treatment plan included interferential Unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One interferential Unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Current Stimulation (ICS), p118-120 Page(s): 118-120.

**Decision rationale:** The claimant is more than six years status post work-related injury and continues to be treated for chronic pain including low back and shoulder pain. When seen, there was decreased shoulder range of motion with positive impingement testing. Authorization for physical therapy, extracorporeal shock wave therapy, and an interferential unit was requested. 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 therefore providing a unit for indefinite use is not medically necessary.