

Case Number:	CM13-0002630		
Date Assigned:	12/27/2013	Date of Injury:	04/08/2012
Decision Date:	02/19/2014	UR Denial Date:	07/02/2013
Priority:	Standard	Application Received:	07/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 42-year-old male who reported an injury on 04/08/2012 due to cumulative trauma while performing normal job duties. The injury ultimately resulted in shoulder arthroscopy for labral tear repair and subacromial decompression with distal clavicle resection. The patient was treated post-surgically with physical therapy and medications. The patient's most recent clinical documentation reported that the patient had no pain complaints and was not taking any pain medication. Objective findings included range of motion of the right shoulder described as 178 degrees in flexion, 50 degrees in extension, 50 degrees in adduction, 180 degrees in abduction, and 85 degrees in internal and external rotation. Physical findings of the left shoulder included range of motion described as 180 degrees in flexion, 50 degrees in extension, 50 degrees in adduction, 180 degrees in abduction, and 90 degrees in internal and external rotation. The patient's diagnoses included status post right shoulder arthroscopy and bilateral shoulder sprains. The patient's treatment plan included continuation of a home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

The request for a 2 month rental of an OrthoStim 4 unit with supplies XXXXXXXXXX

Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Galvanic Stimulation, Interferential Current Stimulation (ICS), Neuromuscular electrical stimula.

Decision rationale: The requested 2 month rental of an OrthoStim 4 unit with supplies is not medically necessary or appropriate. The requested equipment is a 4 module stimulator that includes an interferential current, galvanic pulsed current, neuromuscular stimulation, and direct pulse current. California Medical Treatment Utilization Schedule does not recommend the use of interferential current stimulation as an isolated intervention. However, the clinical documentation does indicate that the patient is participating in a home exercise program. Therefore, a 1 month trial would be appropriate for patients with ineffectively controlled pain. The clinical documentation submitted for review does not provide any evidence that the patient has significant limitations due to pain and is nonresponsive to medications. California Medical Treatment Utilization Schedule does not recommend the use of neuromuscular electrical stimulation devices for the treatment of chronic pain. Additionally, galvanic stimulation is not supported by California Medical Treatment Utilization Schedule as it is considered investigational for all indications. As the OrthoStim 4 unit is a compounded device that consists of stimulators that are not recommended by California Medical Treatment Utilization Schedule, this device would not be indicated. As such, the requested 2 month rental of OrthoStim 4 unit and supplies is not medically necessary or appropriate.