

Case Number:	CM13-0025332		
Date Assigned:	12/18/2013	Date of Injury:	03/10/2011
Decision Date:	02/04/2014	UR Denial Date:	09/12/2013
Priority:	Standard	Application Received:	09/17/2013

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, has a subspecialty in Pain Management and is licensed to practice in Ohio and Texas. 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 female who reported an injury on 03/10/2011. The mechanism of injury was noted to be a fall. It was noted that the patient had right shoulder arthroscopic surgery on 11/03/2011 followed by a course of physical therapy that ended in 04/2012. The patient's symptoms included intermittent neck pain that increases with lifting to or above the shoulder level. The physical exam findings included decreased range of motion of the cervical spine, pain with range of motion of the cervical spine, tenderness to palpation of the paraspinal musculature, negative Spurling's test, decreased range of motion of the right shoulder, and tenderness to palpation of the right shoulder. She was also noted to have decreased motor strength in the right upper extremity. Her diagnoses were listed as chronic neck pain secondary to chronic right shoulder pain, status post revision right shoulder arthroscopy with excision of the distal clavicle on 10/02/2013, status post right elbow injury with surgically removed "klenoid" scar, and complaints of depression, anxiety, stress, and difficulty sleeping. The patient noted that her pain had decreased some since her recent surgery on 10/02/2013, and she had begun postoperative physical therapy. It was noted that the patient had not attained maximum medical improvement, and recommendation was made for continuing physical therapy and aggressive home-based exercises.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME Interferential Stimulator (Rental Extension): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines the Chronic Pain Medical Treatment Guidelines Transcutaneous Electrotherapy, Interferential Curr.

Decision rationale: California MTUS Guidelines state that interferential current stimulation 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. The criteria for use of an interferential stimulation unit is the pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercise programs or physical therapy treatment, or unresponsive to conservative measures such as repositioning, heat/ice, etc. The guidelines further state if those criteria are met, then a 1 month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain, and evidence of medication reduction. A request was made for a rental extension for an interferential stimulator. The patient was noted to be participating in postoperative physical therapy. However, the clinical information submitted for review did not include documentation of increased functional improvement, less reported pain, and evidence of medication reduction, with a trial of an interferential stimulator unit. With the absence of this documentation, a rental extension on an interferential stimulator unit is not supported. Therefore, the request is non-certified.