

Case Number:	CM13-0027963		
Date Assigned:	11/22/2013	Date of Injury:	01/14/2013
Decision Date:	01/21/2014	UR Denial Date:	09/09/2013
Priority:	Standard	Application Received:	09/23/2013

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 Emergency Medicine and General Medicine and is licensed to practice in California. 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:

Patient is a 49 year-old male with injury on 1/14/13 from lifting incident with complaint of R shoulder pain. Diagnosed with R shoulder impingement syndrome, facet syndrome and cervical and lumbar strain. Prior hx of R shoulder rotator cuff repair on 1997. X-rays from 1/15/13 show foraminal narrowing on R at C3-4 and C4-5 and post-op changes in shoulder and scapular along with mild degenerative joint disease (DJD). MRI on 2/22/13 of shoulder and low back reveals DJD, tendinitis and post op changes of the R shoulder and annular tear of L4-5 and multilevel disk bulges. EMG of lower extremities on 4/15/13 was normal. EMG of shoulder on 8/26/13 was normal. Physical exam reports R shoulder decreased ROM and positive for impingement. Cervical and lumbar spine has decreased ROM and tenderness and absent reflexes on both upper extremities. Also reports of psychiatric and sleep problems since injury. Also reports of umbilical hernia which has been repaired. Patient has received physical therapy, medication, shoulder injections, back brace, chiropractic and acupuncture attempts. Patient is requesting purchase of Interspec Interferential Unit 2 device along with 12 month supply for the unit. Utilization review dated 9/9/13 recommended non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interspec Interferential Unit II for purchase: 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
Transcutaneous electrotherapy: Interferential Current Stimulation Page(s): 118-120.

Decision rationale: As per MTUS chronic pain treatment guidelines, interferential current stimulation is not recommended due to lack or very poor evidence of efficacy and is not recommended in isolation. It may be considered if failed pain management after conservative or medication therapy. If these criteria are met, then it may be considered for a 1month trial with documentation of improvement. There is no documentation at attempts at a 1month trial and improvement, therefore the device is not medically necessary.

Twelve (12) month's supply of Interspec Interferential Unit II supplies: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.