

Case Number:	CM13-0041186		
Date Assigned:	12/20/2013	Date of Injury:	06/10/2009
Decision Date:	02/06/2014	UR Denial Date:	09/27/2013
Priority:	Standard	Application Received:	10/11/2013

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 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:

This 48 year-old female sustained an injury on 6/10/09 while employed by [REDACTED]. Request under consideration include Home Interferential Unit/Ortho Stimulator IV. She is status post right shoulder arthroscopy, Mumford procedure and MUA on 3/10/11. Report of 3/5/13 from [REDACTED] noted complaints of right shoulder and left wrist pain. Exam showed right shoulder tenderness at AC joint and subacromial bursa; crepitus and range of motion ff 165 degrees, abduction 170 degrees, ER/IR 60 degrees; right wrist with negative Tinel's; presence of dorsal ganglion cyst. Diagnoses included s/p right shoulder surgery; right wrist sprain; DeQuervain's tenosynovitis. Treatment included continued home exercise program. Report of 9/12/13 noted ongoing left shoulder pain with decreased motion and weakness. Symptoms are controlled with medications and exercise. Exam showed same tenderness with similar range of ff 160, ext 34, abd 165, ER/IR 70 degrees; negative Tinel's, Phalen's and Finkelstein's. Treatment plan for Voltaren, Lidoderm patches, diagnostic ultrasound, and home interferential unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Interferential Unit/Ortho Stimulator IV: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy section Page(s): 114-11.

Decision rationale: The Physician Reviewer's decision rationale: This 48 year-old female sustained an injury on 6/10/09 while employed by [REDACTED]. Request under consideration include Home Interferential Unit/Ortho Stimulator IV. She is status post right shoulder arthroscopy, Mumford procedure and MUA on 3/10/11. Report of 3/5/13 from [REDACTED] noted complaints of right shoulder and left wrist pain. Exam showed right shoulder tenderness at AC joint and subacromial bursa; crepitus and range of motion ff 165 degrees, abduction 170 degrees, ER/IR 60 degrees; right wrist with negative Tinel's; presence of dorsal ganglion cyst. Diagnoses included s/p right shoulder surgery; right wrist sprain; DeQuervain's tenosynovitis. Treatment included continued home exercise program. Report of 9/12/13 noted ongoing left shoulder pain with decreased motion and weakness. Symptoms are controlled with medications and exercise. Exam showed same tenderness with similar range of ff 160, ext 34, abd 165, ER/IR 70 degrees; negative Tinel's, Phalen's and Finkelstein's. Treatment plan for Voltaren, Lidoderm patches, diagnostic ultrasound, and home interferential unit. Per MTUS Chronic Pain Treatment Guidelines, interferential stimulation is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of transcutaneous stim unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. It appears the patient has received extensive conservative treatment to include medications and exercise which is documented to control his symptoms. There is no documentation on the short-term or long-term goals of treatment with the interferential unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the Home Orthostim unit purchase as there is no documented failed trial of TENS. There is no evidence for change in work status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from any transcutaneous stimulation therapy already rendered. The Home Interferential Unit/Ortho Stimulator IV is not medically necessary and appropriate.