

Case Number:	CM14-0100054		
Date Assigned:	09/16/2014	Date of Injury:	09/14/2012
Decision Date:	10/22/2014	UR Denial Date:	06/23/2014
Priority:	Standard	Application Received:	06/28/2014

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. The expert 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 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/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 injured worker is a 50-year-old male who sustained an injury on 9/14/12. On 5/15/14 the patient presented with complaints of right shoulder pain with restricted motion and weakness. On exam, there was tenderness and impingement. The patient is status post right shoulder massive rotator cuff repair, decompression on 10/2/13. He was reportedly taking Norco, Percocet, and Anaprox. He had medication induced heart burn. Past treatment included acupuncture, physical therapy, chiropractic therapy and medications. He was treated with acupuncture and had residual pain with forceful use of activities with above shoulder level and reported increased range of motion. Current treatment plan is to get interferential unit and ultrasound guided subacromial injection; Diagnoses: Right shoulder sprain/strain with a full thickness supraspinatus tendon tear, biceps tenosynovitis, acromioclavicular joint and glenohumeral joint osteoarthritis per right shoulder MRI dated November 19, 2012, and cervical spine and trapezial muscle sprain/strain. The request for Inferential unit and Inter right subacromial ultrasound guided injection was denied on 6/23/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Inferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation Page(s): 120.

Decision rationale: Per guidelines, 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. Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or due to side effects; or history of substance abuse; or significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-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. In this case, the medical records do not document this device is indicated, as the criteria are not met. Furthermore, there is no documentation of one month trial of this device. Therefore, the request is not medically necessary.

Inter right subacromial ultrasound guided injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder

Decision rationale: Per ODG, shoulder steroid injection criteria include: diagnosis of adhesive capsulitis, impingement syndrome or rotator cuff problems; pain not controlled adequately by recommended conservative treatment (PT, NSAIDs) after at least 3 months; pain interferes with functional activities; intended for short-term control of symptoms to resume conservative medical management; generally performed without fluoroscopy or ultrasound. In this case, there is limited documentation as to previous conservative treatments. Furthermore, the above criteria are not met. Thus, the request is considered not medically necessary.