

Case Number:	CM14-0012523		
Date Assigned:	02/21/2014	Date of Injury:	11/20/2007
Decision Date:	07/24/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	01/30/2014

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 Anesthesiology and has a subspecialty in Pain Management 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 patient is a 50-year-old female who has submitted a claim for right shoulder impingement syndrome, cervical sprain / strain, lumbar disc protrusion, major depression, adjustment disorder with anxiety, systemic lupus erythematosus, fibromyalgia, hypertension, GERD, hyperlipidemia, and diabetes mellitus associated with an industrial injury date of 11/20/2007. Medical records from 2013 to 2014 were reviewed. Patient complained of right shoulder pain, graded 7/10 in severity. This resulted to difficulties with pushing, pulling, and overhead reaching. Blood pressure was measured at 153/79 mmHg, heart rate of 84 beats per minute and capillary blood glucose of 235 mg/dL. Cardiovascular exam was unremarkable. Epigastric tenderness was noted. Physical examination of the right shoulder showed restricted range of motion, tenderness, muscle guarding, and weakness graded 4/5. Impingement test and Cross-arm test were positive. Treatment to date has included physical therapy, extracorporeal shockwave therapy, subacromial cortisone injection, and medications such as Prozac, ibuprofen, lisinopril, Dexilant, Tricor, Crestor, metformin, Sentra AM, and Sentra PM. Utilization review from 01/22/2014 denied the requests for interferential unit month rental with supplies (electrodes, power pack, adhesive remover towel mint, s&h) and additional 1 month rental if unit with supplies (electrodes, power pack, adhesive remover towel mint, s&h) because there was no discussion why a TENS unit would not suffice.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF UNIT MONTH RENTAL WITH SUPPLIES (ELECTRODES, POWER PACK, ADHESIVE REMOVER TOWEL MINT, S&H): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: As stated on pages 118-120 of the California MTUS Chronic Pain Medical Treatment Guidelines, interferential current stimulation is not recommended as an isolated intervention but is an adjunct for recommended treatments including return to work, exercise, and medications. A one-month trial should be done given that the patient's pain is ineffectively controlled by medications, or unresponsive to conservative measures. In this case, patient complained of persistent right shoulder pain despite conservative treatment involving physical therapy, extracorporeal shockwave therapy, subacromial cortisone injection, and intake of medications. The documented rationale is to provide interferential current stimulation therapy together with a home exercise program while awaiting authorization for right shoulder surgery. IF therapy is a reasonable option at this time. Therefore, the request for IF Unit month rental with supplies (electrodes, power pack, adhesive remover towel mint, s&h) is medically necessary.

ADDITIONAL 1 MONTH RENTAL IF UNIT WITH SUPPLIES (ELECTRODES, POWER PACK, ADHESIVE REMOVER TOWEL MINT, S&H): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: As stated on pages 118-120 of the California MTUS Chronic Pain Medical Treatment Guidelines, interferential current stimulation is not recommended as an isolated intervention but is an adjunct for recommended treatments including return to work, exercise, and medications. A one-month trial should be done given that the patient's pain is ineffectively controlled by medications, or unresponsive to conservative measures. In this case, patient complained of persistent right shoulder pain despite conservative treatment involving physical therapy, extracorporeal shockwave therapy, subacromial cortisone injection, and intake of medications. The documented rationale is to provide interferential current stimulation therapy together with a home exercise program while awaiting authorization for right shoulder surgery. IF therapy is a reasonable option at this time. Patient was already certified to use a one-month rental of interferential unit. Functional benefits and pain relief should be documented prior to certifying extension of the requested service. The medical necessity was not established. Therefore, the request for additional 1 month rental IF Unit with supplies (electrodes, power pack, adhesive remover towel mint, s&h) is not medically necessary.

