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| Case Number: | CM14-0152511 | | |
| Date Assigned: | 09/22/2014 | Date of Injury: | 02/17/2010 |
| Decision Date: | 10/21/2014 | UR Denial Date: | 08/27/2014 |
| Priority: | Standard | Application Received: | 09/18/2014 |

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 Family 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 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:

This is a 41-year-old male patient who reported an industrial injury to the left shoulder on 2/17/2010, over 4 years ago, attributed to the performance of his usual and customary job tasks reported as having his glove caught in a drill bit resulting in a twisting of the hand and arm. The patient complained of left shoulder pain that is constant and aggravated with movements. The patient also complained of neck and back pain. The objective findings on examination included limited range of motion to the cervical spine; tenderness to the paraspinal muscles with spasm; abduction left shoulder was 90 flexion 100. The diagnoses included cervical disc protrusion; left shoulder impingement; status post left shoulder surgical intervention; adhesive capsulitis. The treatment plan included an interferential muscle stimulator directed to the postoperative left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Stimulator Unit for the left shoulder: 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 transcutaneous electrotherapy; interferential current stimulation Page(s): 115, 118-121. Decision

based on Non-MTUS Citation Official Disability Guidelines (ODG) lower back chapter-interferential therapy; pain chapter-interferential current stimulation

Decision rationale: The request for authorization for an interferential muscle stimulator provided no objective evidence to support the medical necessity of the interferential muscle stimulator directed to the postoperative left shoulder and override the recommendations of the provided evidence-based guidelines. There was no peer reviewed objective evidence that was accepted by the national medical community to support the medical necessity of the IF unit for the treatment of chronic pain to the shoulder status post arthroscopic surgical intervention. The request is inconsistent with the recommendations of the CA MTUS for the use of electric muscle stimulators. The request for authorization of the IF muscle stimulator was not supported with objective evidence or any clinical documentation to support the medical necessity of this device for the treatment of the neck and back. There is no demonstrated medical necessity for the use of this specific electrical stimulator. As outlined below, the ACOEM Guidelines 2nd edition states that there is insufficient evidence to support the use of interferential muscle stimulation. The chronic pain chapter of the ACOEM Guidelines does not recommend the use of IF Units for the treatment of chronic neck and back pain. The Official Disability Guidelines do not recommend the use of an Interferential Muscle stimulator unit as an isolated intervention; however, if used anyway there are certain criteria to meet prior to authorization. The requested IF unit with purchase of supplies is an IF stimulator that is reported by the vendor to provide interferential stimulations for pain relief. The Avid IF unit was requested to treat the postoperative left shoulder. Evidence-based guidelines do not support the use of NMES or interferential muscle stimulation for the treatment of the neck or cervical spine, or shoulder. Since the Interferential, muscle stimulation components are not recommended by evidence-based guidelines, and then the whole device is not recommended or considered to be medically necessary or reasonable for the treatment of the postoperative left shoulder. The use of a neuromuscular stimulator for the reduction of pain or control spasms is not demonstrated to be medically necessary/reasonable or meet the criteria recommended by the currently accepted evidence-based guidelines. The CA MTUS does not recommend the use of Interferential Muscle Stimulators for neck, back, shoulder pain. The CA MTUS and the Official Disability Guidelines only recommends the use of the TENS unit for chronic lower back pain with a demonstrated exercise program for conditioning and strengthening. The TENS Unit is recommended for only chronic intractable pain. The Official Disability Guidelines state that there is insufficient evidence to support the use of the requested IF unit for the treatment of subacute thoracic and low back pain. There was no provided documentation that the patient was participating in a self-directed home exercise program for the effects of the industrial injury. The ACOEM Guidelines revised back chapter 4/07/08 does recommend the use of the Tens Unit for the treatment of chronic lower back pain; however, it must be as an adjunct to a functional rehabilitation program and ongoing exercise program. The CA MTUS and the Official Disability Guidelines only recommend the use of the Tens Unit for chronic lower back pain with a demonstrated exercise program for conditioning and strengthening. There are no recommendations for the use of the IF Electrical muscle stimulator unit in the treatment of chronic neck, back, or shoulder pain. The evidence-based guidelines discuss the ineffectiveness/side effects of medications; history of substance abuse; or an inability to respond to conservative treatment or perform physical therapy, which are not documented by the requesting physician. There is no demonstrated medical necessity for the rental/purchase of the interferential muscle stimulator with supplies/electrodes. There is no demonstrated medical necessity for the prescribed interferential muscle stimulator directed to the postoperative left shoulder. Therefore, this request is not medically necessary.