MAXIMUS Federal Services

Case Number:	CM14-0035435		
Date Assigned:	06/23/2014	Date of Injury:	12/31/2010
Decision Date:	07/18/2014	UR Denial Date:	03/10/2014
Priority:	Standard	Application Received:	03/21/2014

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 patient is a 58 year old female with an injury date on 12/31/2010. Based on the 02/28/2014 progress report provided by [redacted] the patient presents with left shoulder pain, neck pain and stiffness. The diagnoses are: 1. Sprain shoulder/arm. 2. Rotator cuff syndrome. 3. Sprain of neck. 4. Thoracic/lumbar disc displacement. Exam on 02/28/2014 showed cervical spine was tender to palpated, pain with compression. The patient describes the pain as frequent moderate sharp pain, with pain at 6 out of 10. [redacted] is requesting Interferential stimulator for 1 month rental with purchase of supplies: electrodes 4 pack, power packs 12, adhesive remover towel mint X16, TT &SS lead wire X1. The utilization review determination being challenged is dated 03/10/2014. [redacted] is the requesting provider, and he provided treatment reports from 12/17/2013 to 06/03/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential stimulator x1 month rental with purchase of supplies: electrodes 4 pack, power packs x12, adhesive remover towel mint x16, TT & SS leadwire x1: Upheld

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

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

Decision rationale: This patient presents with frequent moderate sharp pain in the left shoulder and neck. The treating physician has asked for Interferential stimulator for 1 month rental with purchase of supplies per 02/28/2014 report. Examination showed positive compression test, cervical spine tenderness to palpation, decreased sensation at C4-C7 levels. The request was denied by utilization reviewer with the rationale that there was lack of clinical documentation for the need. Regarding interferential stimulator units, California Medical Treatment Utilization Schedule (MTUS) guidelines pages 118-120 do 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. MTUS further states that while IF unit is not recommended as an isolated intervention, patient selection criteria if IF unit is to be used anyway are: 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:1.Pain is ineffectively controlled due to diminished effectiveness of medications; or2. Pain is ineffectively controlled with medications due to side effects; or3. History of substance abuse; or4. Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or5. Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.).If these criteria are met, then a one-month trial is supported. In this case, there is no evidence that pain is ineffectively controlled from medication, intolerable side effect, history of substance abuse; and the patient is not post-operative. Treatment is not medically necessary and appropriate.