

Case Number:	CM14-0057561		
Date Assigned:	07/09/2014	Date of Injury:	01/09/2013
Decision Date:	09/25/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/28/2014

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 has a subspecialty in Interventional Spine 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 39 year old female with an injury date of 01/09/13. The 03/19/14 report by ■■■ states that the patient presents with right shoulder ache and limited range of motion. Pain is rated 1/10. She is released to full duty with no restrictions effective 03/20/14. Examination reveals upper arm tenderness and limited range of motion. The patient's diagnoses include: Rotator cuff (capsule) and other affections of the shoulder region not otherwise classified. The patient underwent a diagnostic and operative arthroscopy of the right shoulder 06/21/13. The utilization review being challenged is dated 04/01/14. Treatment reports were provided from 04/09/13 to 03/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF (Interferential) Unit (E1399) 30-60 day rental and/or purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
INTERFERENTIAL CURRENT STIMULATION (ICS) Page(s): 118-120.

Decision rationale: The patient presents with right shoulder pain rated 1/10 with limited range of motion. The treater requests for 1 IF (Interferential) Unit (E1399) 30-60 day rental and/or purchase trial to manage pain and reduce medication. MTUS pages 118 to 120 state that Interferential Current Stimulation (ICS) 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. MTUS further states, "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: 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- Pain is ineffectively controlled with medications 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. The treater does discuss some elements that the requested IF unit would not be an isolated intervention in that the patient is cleared to return to work and she has been undergoing physical therapy; however, there is no discussion of current medications or an exercise program. The patient does not meet the above criteria as pain does appear controlled at 1/10 after improving from 3/10 since 11/03/13. The patient is documented to be responsive to the conservative measure of applying ice to her shoulder to alleviate some symptoms. There is no discussion that the patient meets the other selection criteria listed above. Therefore, recommendation is for denial.