

Case Number:	CM14-0067259		
Date Assigned:	07/11/2014	Date of Injury:	05/20/2009
Decision Date:	09/19/2014	UR Denial Date:	04/17/2014
Priority:	Standard	Application Received:	05/12/2014

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 56-year-old, who reported an injury on May 20, 2009. The mechanism of injury was not specifically stated. The current diagnosis is right glenohumeral osteoarthritis. It is noted that the injured worker is status post right total shoulder arthroplasty. The injured worker has also undergone bilateral knee surgeries. Previous conservative treatment includes physical therapy and medication management. The current medication regimen includes Norco 10/325 mg. The injured worker was evaluated on 01/16/2014 with complaints of weakness in the right upper extremity. The injured worker was actively participating in physical therapy twice per week. Physical examination revealed a well healed surgical scar, intact sensation, 160/90/20 degree range of motion, and 4/5 abduction strength. Treatment recommendations at that time included continuation of physical therapy twice per week for six weeks and continuation of the home interferential stimulation. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Two month rental of a home interferential (IF) stimulation unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state interferential current stimulation is not recommended as an isolated intervention. There should be evidence that pain is ineffectively controlled due to the diminished effectiveness of medications or side effects, a history of substance abuse, or significant pain from postoperative conditions. There is no documentation of a failure to respond to conservative measures. The Chronic Pain Medical Treatment Guidelines further state, if the device is to be used, a one-month trial should be initiated and evidence of resulting pain and functional improvement must be documented. While it is noted that the injured worker reported an improvement in symptoms with the use of interferential current stimulation, there is no documentation of a significant functional improvement. As such, the current request cannot be determined as medically appropriate at this time. Therefore, the request for a two-month rental of a home interferential (IF) stimulation unit is not medically necessary or appropriate.