MAXIMUS Federal Services

Case Number:	CM14-0207338		
Date Assigned:	12/19/2014	Date of Injury:	06/10/2010
Decision Date:	02/19/2015	UR Denial Date:	11/06/2014
Priority:	Standard	Application Received:	12/10/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, District of Columbia, Maryland
Certification(s)/Specialty: Anesthesiology, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

64y/o female injured worker with date of injury 6/10/10 with related left shoulder pain. Per progress report dated 10/24/14, physical exam revealed tender paraspinals about the lumbar and cervical spine. It was noted that she underwent left arthroscopic shoulder surgery on 10/8/14 and was awaiting post acute rehab. It was also noted that her home stimulation unit was no longer functioning and was not fixable. Progress report was handwritten and illegible. Treatment to date has included surgery, physical therapy, and medication management.The date of UR decision was 11/6/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential stimulator; 1 month rental, then convert to purchase or continued rental if effective with 6 months supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, interferential current stimulation.

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

Decision rationale: Per MTUS CPMTG with regard to interferential current stimulation: "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." As the requested treatment is not recommended by the MTUS, and has only limited evidence of improvement when used in conjunction with other recommended treatments, the request is not medically necessary.

Left shoulder x-ray: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

Decision rationale: Per the ACOEM guidelines: Routine testing (laboratory tests, plain-film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain. Primary criteria for ordering imaging studies are: - Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems); - Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon); - Failure to progress in a strengthening program intended to avoid surgery; - Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The injured worker was post-op, in the acute stages of healing. The request is medically necessary.

Physical therapy; 24 sessions (3 x 4, then 2 x 4, then 1 x 4), left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine,Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: Per MTUS CPMTG, physical medicine guidelines state: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. ODG Physical Therapy Guidelines - Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12): Post-surgical treatment, arthroscopic: 24 visits over 14 weeks. The records submitted for review indicate that the injured worker was certified 12 visits of post-op physical therapy per UR dated 9/3/14. It is not documented whether these sessions were completed. As the request would total to more sessions than the recommended amount, the request is not medically necessary.