

Case Number:	CM15-0105671		
Date Assigned:	06/10/2015	Date of Injury:	01/23/2006
Decision Date:	07/13/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	06/02/2015

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: New Jersey, Alabama,
California

Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 49 year old male who sustained an industrial injury on 01/23/2006. Mechanism of injury was not documented. Diagnoses include rotator cuff sprain, status post-surgery. Treatment to date has included diagnostic studies, medications; status post left shoulder arthroscopy with acromioplasty, Mumford procedure, biceps tendon tenodesis, lysis of adhesion, subacromial bursectomy, removal of loose bodies and debridement of glenoid labrum on 02/09/2015, and physical therapy. A physician progress note dated 05/14/2015 documents the injured worker complains of persistent pain and anterior tenderness to the left shoulder. There is weakness in the internal and external rotation showing 4 out of 5. A physician order dated 05/04/2015 notes the injured worker has pain, restricted range of motion and that pain limits the ability to perform exercise/physical therapy treatment. The purchase of an interferential stimulator and continued necessary supplies was ordered. Treatment requested is for DME left shoulder Surgi-Stim Unit Purchase, electrodes x 3 Non Sterile Electrodes x 1, Batteries x 12 Adhesive Remover Wipes x 16, and Lead Wires x 2.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME Left Shoulder Surgi-Stim Unit Purchase Electrodes x 3 Non Sterile Electrodes x 1 Batteries x 12 Adhesive Remover Wipes x 16 Lead Wires x 2: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

Decision rationale: According to MTUS guidelines, "Interferential Current Stimulation (ICS) 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. (Van der Heijden, 1999) (Werner, 1999) (Hurley, 2001) (Hou, 2002) (Jarit, 2003) (Hurley, 2004) (CTAF, 2005) (Burch, 2008) The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. 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.)". There is no clear evidence that the patient did not respond to conservative therapies, or have post op pain that limit his ability to perform physical therapy. There is no clear evidence that the neurostimulator will be used as a part of a rehabilitation program. In addition, there is no TENS unit trial. Therefore, the request for Left Shoulder Surgi-Stim Unit Purchase Electrodes x 3 Non Sterile Electrodes x 1 Batteries x 12 Adhesive Remover Wipes x 16 Lead Wires x 2 is not medically necessary.