

Case Number:	CM15-0185998		
Date Assigned:	09/28/2015	Date of Injury:	02/15/2011
Decision Date:	11/18/2015	UR Denial Date:	09/15/2015
Priority:	Standard	Application Received:	09/21/2015

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: Pennsylvania, Ohio, California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 female, who sustained an industrial injury on 2-15-11. The injured worker is being treated for dislocation of the knee and shoulder injury. X-rays revealed no increase of osteoarthritis in left knee or left shoulder. Previous treatment is not documented. On 5-13-15 the injured worker complains of continued pain to the left shoulder as well as pain to the left knee with improvement since previous visit and on 8-26-15, the injured worker returns for a follow up exam of her left shoulder and left knee, she complains of left shoulder pain with radiation down the arm to hand and fingers, rated 7 out of 10. Work status is noted to be return to modified duties; however it is unclear if she is working. Physical exam performed on 8-26-15 revealed limited range of motion and an antalgic gait. The treatment plan included a request for physical therapy e times a week for 4 weeks; interferential unit for 30 to 60 day rental and prescriptions for Cyclobenzaprine 7.5mg, Diclofenac 100mg #60, Tramadol ER 150 #30 and Pantoprazole ER 20mg #60. On 9-15-15 a request for Interferential unit 60 days rental for left shoulder-knee was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF Unit 60 Days Rental (Purchase if effective) for Left Shoulder/Knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: MTUS recommends interferential stimulation as an option in specific clinical situations after first-line treatment has failed. Examples of situations where MTUS supports interferential stimulation include where pain is ineffectively controlled due to diminished effectiveness of medication or medication side effects or history of substance abuse. The records do not document such a rationale or alternate rationale as to why interferential stimulation would be indicated rather than first-line treatment. Therefore this request is not medically necessary.