

Case Number:	CM15-0198919		
Date Assigned:	10/14/2015	Date of Injury:	09/18/2014
Decision Date:	11/24/2015	UR Denial Date:	09/25/2015
Priority:	Standard	Application Received:	10/09/2015

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: Florida

Certification(s)/Specialty: Family Practice

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 57 year old female, who sustained an industrial injury on 9-18-2014. The injured worker was diagnosed as having cervical spine musculoligamentous sprain-strain with bilateral upper extremity radiculitis, thoracolumbar musculoligamentous sprain-strain with left sided sacroiliac joint sprain, right shoulder tendinitis and impingement (rotator cuff per patient history), status post left shoulder arthroscopic surgery with Mumford procedure, and adhesive capsulitis. Treatment to date has included diagnostics, left shoulder surgery 6-17-2015, physical therapy, and medications. Currently (8-27-2015), the injured worker complains of neck pain radiating to the arms, bilateral shoulder pain, and left sacroiliac and back pain. Exam noted that she was right hand dominant. Exam of the cervical spine noted forward head carriage, tenderness to palpation with hypertonicity over the bilateral paraspinal musculature and upper trapezius muscles, increased localized neck pain with Spurling's maneuver, and decreased range of motion. Exam of the thoracolumbar spine noted tenderness to palpation with hypertonicity over the bilateral paraspinal musculature, tenderness to palpation over the left sacroiliac joints, left sacroiliac joint stress positive for pain in this region, positive Fabere's for increased pain in the sacroiliac joint, and decreased range of motion. Exam of the bilateral shoulders noted a sling on the left, diffuse tenderness to palpation bilaterally, positive impingement bilaterally, decreased range of motion (left greater than right), and 4 of 5 weakness on the left in all planes and on the right with resisted flexion and abduction. Current medication regimen was not noted. Work status was total temporary disability. Per the request for

Authorization dated 8-27-2015, the treatment plan included a Rehab chair (left shoulder) for purchase and an interferential unit for home use for purchase, non-certified by Utilization Review on 9-25-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Rehab chair for purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Power Mobility Devices, [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN Products/downloads/pmd_DocCvg_FactSheet_ICN905063.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN%20Products/downloads/pmd_DocCvg_FactSheet_ICN905063.pdf).

Decision rationale: A rehab chair for purchase is being requested. This patient is postoperative from a left shoulder arthroscopic surgery for adhesive capsulitis. It is unclear why a rehab chair is being requested for the treatment of a left shoulder condition. Furthermore, no specifics have been provided regarding what type of a rehabilitation chair is being requested (mechanical or motorized, etc). No physical therapy evaluation has been performed that supports the medical necessity of this rehab chair purchase. Likewise, this request is not medically necessary.

Interferential unit for purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Interferential Current Stimulation (ICS) MTUS, pg 127 - 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. 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. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only

with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. Regarding this patient's case, she is undergoing postoperative physical therapy. However, there is no documentation that her pain is not well controlled with medications. There is also no documentation provided that indicates that she is unable to perform physical therapy due to significant postoperative pain. Therefore, this request for an IF stimulation device is not medically necessary as MTUS guidelines are not satisfied.