

Case Number:	CM15-0042979		
Date Assigned:	03/13/2015	Date of Injury:	02/28/2013
Decision Date:	05/01/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	03/06/2015

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: California, Washington

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

The injured worker is a 47-year-old male who reported an injury on 02/28/2013. The mechanism of injury was a motor vehicle accident. The injured worker underwent a left shoulder arthroscopic decompression; rotator cuff repair, possibly open; excision/acromioplasty, clavicle for the left shoulder. The injured worker underwent an MRI of the left upper extremity, which revealed a rotator cuff tear measuring 2.5 cm and retraction of the supraspinatus, effusion, and degenerative arthritis of the AC joint of the left shoulder. The MRI was performed on 08/13/2014. The documentation of 01/05/2015 revealed that the injured worker was noted to have difficulty with self-care, physical activity, sensory function, travel, and work activities, as well as sexual function. The physical examination revealed the injured worker had difficulty with his right shoulder; however, the left shoulder was noted to be addressed. The injured worker had pain with flexion and a positive impingement sign and with any attempt to place the arm behind the back. There was normal sensation and motor power. The recommendation was to perform and arthroscopy of the shoulder. The documentation of 01/16/2015 revealed the injured worker had complaints of neck pain that radiated down the left shoulder and left upper extremity rated a 6/10. The medications included ibuprofen 800 mg tablets and tramadol 50 mg tablets. The physical examination revealed palpable tenderness over the lateral aspect of the right shoulder and over the right trapezius. The treatment plan included a left shoulder open subacromial decompression and open rotator cuff repair. The diagnosis included bilateral shoulder impingement syndrome. The request was made for a shower bar, additional physical therapy for the lumbar spine, and left shoulder surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shoulder exercise kit: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend physical medicine. The clinical documentation submitted for review indicated the injured worker was to undergo left shoulder surgery. However, the components for the exercise kit were not provided. As such, they could not be addressed individually. There was no physician documentation requesting the shoulder exercise kit. Given the above and the lack of documentation, the request for shoulder exercise kit is not medically necessary.

IF unit Qty: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ICS Page(s): 114-121.

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

Decision rationale: The California Medical Treatment Utilization Schedule guidelines do not recommend interferential current stimulation (ICS) as an isolated intervention and it should be used with recommended treatments including work, and exercise. The clinical documentation submitted for review failed to indicate whether the unit would be utilized with an exercise program. Additionally, the request as submitted failed to indicate the frequency, duration, and whether the unit was for rental or purchase. Given the above, the request for IF unit, quantity 1 is not medically necessary.

IF Electrodes (months' worth of supplies) Qty:3: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.