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| Case Number: | CM15-0057756 | | |
| Date Assigned: | 04/02/2015 | Date of Injury: | 08/08/2013 |
| Decision Date: | 05/08/2015 | UR Denial Date: | 03/19/2015 |
| Priority: | Standard | Application Received: | 03/26/2015 |

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

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 36 year old male, who sustained an industrial injury on August 8, 2013. He reported injury to his right shoulder, lumbar and lumbo-scaral area. The injured worker was diagnosed as having right shoulder recalcitrant rotator cuff impingement and labral tear. Treatment to date has included diagnostic studies, surgery, injections, physical therapy, home exercise program and medications. On March 2, 2015, notes stated that the injured worker returned for evaluation of his right shoulder. He is scheduled for a right shoulder arthroscopy with subacromial decompression on March 18, 2015. There were no subjective complaints listed in the report. Physical examination of the right shoulder revealed forward flexion 160 degrees, abduction 60 degrees and external rotation 40 degrees. Impingement sign, Speed's test and Crank test were all positive. The treatment plan included surgery and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF (Interferential) unit, 2 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: The patient presents on 03/09/15 with unrated right shoulder pain for a pre-operative evaluation. The patient's date of injury is 08/08/13. Patient is status post right shoulder arthroscopy with acromial decompression and labral repair on 03/18/15. The request is for IF (INTERFERENTIAL) UNIT, 2 MONTHS. The RFA was not provided. Physical examination of the right shoulder dated 03/17/15 reveals positive impingement test, positive speed test, and positive crank test. Range of motion of the right shoulder is decreased, especially on abduction and external rotation. The patient is currently prescribed Exforge and Lipitor. Diagnostic imaging included MRI arthrogram of the right shoulder dated 11/20/14, significant findings include: "Grade II SLAP lesion... Partial thickness tear supraspinatus tendon at its insertion." Per 03/06/15 progress report, patient is advised to remain off work until 04/15/15. MTUS Chronic Pain Medical Treatment Guidelines, pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: "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." In regard to what appears to be a two month rental of an ICS unit for this patient's post-operative pain, the requesting provider has exceeded recommended duration of therapy. This patient recently underwent a right shoulder arthroscopy with labral repair, debridement, and acromial decompression. MTUS guidelines support the post-operative use of ICS for such procedures, however they specify that a one month trial of the unit is required before additional therapy is considered. Were the request for a 30 day rental or trial the recommendation would be for approval. However, a two month rental exceeds guideline recommendations and cannot be substantiated. The request IS NOT medically necessary.