

Case Number:	CM15-0084397		
Date Assigned:	05/06/2015	Date of Injury:	03/22/2013
Decision Date:	06/15/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/01/2015

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, Indiana, New York
Certification(s)/Specialty: Internal 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 55-year-old female who sustained an industrial injury on 03/22/2013. The injured worker was diagnosed with a left rotator cuff tear. Treatment included diagnostic testing, conservative measures and medications without improvement and the injured worker underwent left shoulder arthroscopy, acromioplasty, and Mumford procedure, lysis of adhesions with subacromial bursectomy, partial synovectomy and removal of loose bodies on March 24, 2015. According to the primary treating physician's progress report on April 1, 2015, the injured worker continues to experience left shoulder pain primarily at night. The injured worker rates her pain level at 5/10. Examination demonstrated weakness to the shoulder with moderate pain. The injured worker is one-week post op. Current medications are listed as Norco, Cyclobenzaprine, Voltaren XR and Pantoprazole. Treatment plan consists of heat and ice, medication regimen, authorization urine drug screening and the current request for an Interferential Stimulation (IF) 30-60 day rental and purchase if effective.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential unit prefer vendor VQ, 30-60 days rental and purchase if effective: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Unit Page(s): 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Interferential Unit.

Decision rationale: Pursuant to the Official Disability Guidelines, interferential unit prefer vendor VQ, 30 - 60 day rental and purchase if effective is not medically necessary. ICS is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with the recommended treatments including return to work, exercise and medications area randomized trials have evaluated the effectiveness of this treatment. The findings from these trials were either negative or insufficient for recommendation due to poor's study design and/or methodologic issues. The Patient Selection Criteria should be documented by the medical care provider for ICS to be medically necessary. These criteria include pain is ineffectively controlled due to diminished effectiveness of medications; due to side effects of medications; history of substance abuse; significant pain from post operative or acute conditions that limit the ability to perform exercise programs or physical therapy; unresponsive to conservative measures. If these criteria are met, then a one-month trial may be appropriate to permit the physician and physical therapy provider to study the effects and benefits. In this case, the injured worker's working diagnoses are other specified disorders of bursa and tendons in the shoulder region; and status post arthroscopy left shoulder. The treating provider is requesting heat, ice and medications. The guidelines recommend interferential unit if the injured worker has significant pain from a postoperative condition that limits the ability to perform exercise programs or physical therapy. It is unclear whether the injured worker will be starting physical therapy. Additionally, the guidelines set the criteria for an Interferential unit. If the criteria are met, a one-month trial may be appropriate to permit the physician and physical therapy provider to study the effects and benefits. The request places the interferential unit rental and purchase in the same request. The request, as written, is inadequate. Consequently, absent clinical documentation meeting the Patient Selection Criteria for Interferential unit and a 30 day clinical trial, interferential unit prefer vendor VQ, 30 - 60 day rental and purchase if effective is not medically necessary.