MAXIMUS Federal Services

Case Number:	CM14-0110367		
Date Assigned:	08/01/2014	Date of Injury:	05/21/2004
Decision Date:	09/29/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/15/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 60 year old male who reported injury on 05/21/2004. The mechanism of injury was not provided. Diagnoses included chronic bilateral shoulder impingement with tendinitis, suspect possible tear. The past treatments included acupuncture, infrared, myofascial release, kinetic exercise, moxibustion and cupping therapy requested once a week for six weeks. The progress note dated 09/09/2013 noted the therapy program was completed. The injured worker had continued painful range of motion on the left more than the right shoulder. The shoulder range of motion was noted to be improved from 150 to 170 degrees of abduction, and 170 degrees of flexion, a home exercise was prescribed and his tramadol was refilled. On 05/14/2014, the progress report noted the injured worker complained of worsening pain to the shoulders, especially the right, and pain to the lateral aspect of the shoulder with the arc of motion. The physical exam revealed a positive impingement test. The injured worker had shoulder flexion to 150 degrees and abduction to 150 degrees. Medications were not listed. The treatment plan requested a heating pad, supplies for an interferential unit and an MRI of the shoulder. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 9 Shoulder Complaints, pages 207-209. The Expert Reviewer's decision rationale:The request for MRI right shoulder is not medically necessary. The injured worker had right shoulder impingement worsened over an 8 month period. The California MTUS/ACOEM guidelines recommend an "MRI for the emergence of a red flag, the physiologic evidence of tissue insult or neurovascular dysfunction (e.g., weakness, edema), failure to progress in a strengthening program intended to avoid surgery, clarification of the anatomy prior to an invasive procedure, limitations persistent for one month or more if surgery is being considered for a specific defect, or to further evaluate the possibility of potentially serious pathology, such as a tumor." There was no evidence of a red flag condition. The injured worker did not have significant weakness or evidence of tissue insult or neurologic dysfunction. There was no documentation of recent failed conservative treatment. The requesting physician's rationale for the request is not indicated within the provided documentation. As such, the request is not medically necessary.

IF (Interferential) unit supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 118-120..

Decision rationale: The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy, pages 118-120.The Expert Reviewer's decision rationale:The request for IF (interferential) unit supplies is not medically necessary. California MTUS guidelines note "interferential current stimulation is not recommended as an isolated intervention." The guidelines note a one month trial of interferential current stimulation may be appropriate if the patient's pain is ineffectively controlled due to diminished effectiveness of medications or side effects, if the patient has a history of substance abuse, if the patient has significant pain from postoperative conditions which limit the ability to perform active treatment modalities, or if the patient is unresponsive to conservative measures. The guidelines note it should be documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine. The guidelines indicate there should be documentation indicating evidence of increased functional improvement, less reported pain, and evidence of medication reduction after the trial to support purchase of the unit. There was no measured documentation of pain. There is a lack of evidence to support failure of other treatment modalities including a Transcutaneous Electrical Nerve Stimulation (TENS) unit. There was no documentation of the demonstrating the frequency at which the unit is used and the efficacy of the interferential. The request does not indicate the specific supplies being requested and the number of each supply being requested. Therefore, the request is not medically necessary.