

Case Number:	CM14-0165695		
Date Assigned:	10/10/2014	Date of Injury:	10/26/2007
Decision Date:	11/12/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/08/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 63-year-old male who reported injury on 10/26/2007. The mechanism of injury was not provided. The medications were not provided. Prior surgical intervention and therapies included a right knee arthroscopy with debridement and partial meniscectomy, and postoperative therapy. The injured worker underwent an MRI of the cervical spine, a sleep study, and echocardiogram, a lumbar MRI, and a right knee MR arthrogram. The documentation of 08/19/2014 revealed the injured worker had a history of right knee, bilateral shoulder, and neck pain. A request was made for a surgical consultation for the right knee, which had been denied. The injured worker had right knee pain that was more significant than his shoulder pain. The injured worker was continuing to have bilateral shoulder pain. The documentation indicated the injured worker had exhausted all conservative measures for the right shoulder and right knee in terms of physical therapy and acupuncture. There was tenderness to palpation along the right knee medial joint line, and reduced range of motion of the right knee. The injured worker had tenderness to palpation and restricted range of motion of the right shoulder. The diagnoses included impingement syndrome right shoulder, and musculoligamentous injury of the right shoulder; tear of the lateral and medial meniscus, right knee; and status post right knee arthroscopic repair. The treatment plan included: the injured worker had an IFC (interferential current unit), which he would continue to use for the right shoulder. There was no documented rationale for the requested interventions. There was a Request for Authorization submitted for the multi-stim unit and shoulder rehab kit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Rental of Multi-Stim Unit + supplies for 5 months: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, NMES, and Interferential Current Stimulation Page(s): 114-116, 121, and 118.

Decision rationale: The California Medical Treatment & Utilization Schedule does not recommend interferential current stimulation (ICS) as an isolated intervention and states it should be used with other recommended treatments, including work and exercise. The MTUS recommends a one-month trial of a TENS unit as an adjunct to a program of evidence-based ongoing treatment modalities within a functional restoration approach for chronic neuropathic pain. Prior to the trial there must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. The California Medical Treatment & Utilization Schedule does not recommend NMES except as part of post-stroke rehabilitation and further states that there is no evidence to support its use in chronic pain. The clinical documentation submitted for review indicated the injured worker had failed conservative treatment. There was a lack of documentation indicating the unit would be utilized as an adjunct to other therapies. Additionally, there was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. The documentation indicated the injured worker was utilizing an interferential current stimulation unit. There was a lack of documentation indicating a failure of the unit. The request for a rental of a multi stim unit plus supplies for 5 months is not medically necessary.

Purchase of 1 Shoulder Home Exercise Rehab Kit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines), Chronic Pain Chapter, Exercise

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Exercise Equipment, Exercise

Decision rationale: The Official Disability Guidelines indicate that exercise is appropriate but that exercise equipment is considered not primarily medical in nature and, therefore, would not be supported. The request as submitted failed to indicate the components for the requested shoulder home exercise rehab kit. There was a lack of documented rationale for the necessity. Given the above, the request for a purchased shoulder home exercise rehab kit #1 is not medically necessary.

