MAXIMUS Federal Services

Case Number:	CM14-0166728		
Date Assigned:	10/13/2014	Date of Injury:	07/08/2011
Decision Date:	11/13/2014	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/09/2014

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 Orthopaedic Surgery, and is licensed to practice in California. 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:

This 55-year-old female library supervisor sustained an industrial injury on 7/8/11 relative to cumulative trauma. Progressive onset of left arm, shoulder, and hand pain, swelling, numbness, stiffness and weakness were reported. Past medical history was positive for hypertension, hyperlipidemia, and myocardial infarction. The patient underwent left shoulder arthroscopic subacromial decompression with Mumford procedure, biceps tenodesis, and manipulation under anesthesia on 11/15/13. She completed a full course of post-operative rehabilitation. The 7/18/14 treating physician report cited grade 8/10 pain. Physical exam documented left shoulder range of motion as flexion 145, extension 40, abduction 135, adduction 40, external rotation 70, and internal rotation 30 degrees. There was severe supraspinatus and acromioclavicular joint tenderness, moderate greater tuberosity tenderness, mild biceps tenderness, positive subacromial crepitus, and 4/5 shoulder strength. There was positive acromioclavicular joint compression and impingement tests. The diagnosis was adhesive capsulitis. Authorization was requested for left shoulder arthroscopy with capsular release, lysis of adhesions, and manipulation under anesthesia. The 9/3/14 treating physician report requested shoulder surgery, continued medication use, and an interferential stimulator unit. The 9/30/14 utilization review certified a request for left shoulder arthroscopy with capsule release, lysis of adhesions and manipulation under anesthesia. The request for an interferential stimulator unit was denied as there was limited documentation of prior use and benefit to support the need for home use of this device.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Stimulator Unit: 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 (ICS) Page(s): 118-120.

Decision rationale: The California MTUS guidelines do not recommend interferential current (IFC) stimulation as an isolated intervention. Guidelines indicate that IFC is possibly appropriate if pain is ineffectively control due to diminished effectiveness of medications or due to medication side effects, there is a history of substance abuse, significant post-operative pain limits ability to perform exercise/physical therapy treatment, or the patient is unresponsive to conservative measures. If those criteria are met, then a one-month trial may be appropriate to study effects and functional benefit. Guideline criteria have not been met. There is no indication that the patient will be unable to perform post-op physical therapy exercise or treatment, or that post-operative pain management will be ineffective. Additionally, this request for an unspecified duration of use is not consistent with guidelines. Therefore, this request is not medically necessary.