

Case Number:	CM14-0094030		
Date Assigned:	09/12/2014	Date of Injury:	03/11/2012
Decision Date:	10/06/2014	UR Denial Date:	06/03/2014
Priority:	Standard	Application Received:	06/20/2014

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 Family Practice and is licensed to practice in Ohio. 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 64-year-old male whose date of injury was 3-11-2012 whereby he injured his right shoulder while moving mattresses. Ultimately, a torn rotator cuff was diagnosed by MRI scan and on 2-18-2013 the injured worker had an arthroscopic repair of his right shoulder. Physical therapy was utilized preoperatively and postoperatively. Progress notes reflect that there is mild range of motion limitations with regard to the right shoulder and tenderness of the shoulder. The injured worker has been prescribed hydrocodone, diclofenac, muscle relaxants, and a proton pump inhibitor. He has also been given a cortisone injection to the right shoulder postoperatively. He was prescribed another round of physical therapy after the cortisone injection however he went to one session and quit because he did not like what they were doing there. An interferential unit was prescribed for a trial basis for 30-60 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF Unit for rental for 30-60 days: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Pain>, <interferential current unit stimulation>

Decision rationale: While not recommended as an isolated intervention, the following patient selection criteria should be documented by the medical care provider for Interferential Current Stimulation (ICS) to be determined to be medically necessary: 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 therapy: - 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 or acute conditions limits the ability to perform exercise programs/physical therapy treatment; or - Unresponsive to conservative measures (e.g., repositioning, heat/ice, medications, etc.). If those 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. 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. If treatment is determined to be medically necessary, as with all other treatment modalities, the efficacy and continued need for this intervention should be periodically reassessed and documented. Treatment of unlimited duration is not recommended. In this instance, it is possible that the injured worker could not tolerate physical therapy because of pain thus prompting the prescription for the IF unit. The guidelines above may allow for a one-month trial in these situations. Because the request was for 30-60 days and not for 30 days, IF Unit for rental for 30-60 days is not medically necessary.