

<b>Case Number:</b>	CM15-0114584		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	05/24/2014
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	05/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/15/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 52 year old male, who sustained an industrial injury on 5/24/2014. She reported slipping on a wet floor, injuring her shoulder and her hand. Diagnoses have included cervical strain and right shoulder strain. Treatment to date has included physical therapy, cortisone injections and medication. According to the progress report dated 4/30/2015, the injured worker complained of right shoulder pain rated 6/10. Objective findings revealed weakness and instability to the right shoulder, as well as increasing pain when lifting objects. The injured worker was to return to modified work with restrictions. Authorization was requested for physical therapy to the right shoulder three times a week for four weeks and an interferential unit to the right shoulder and supplies.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy to the right shoulder 3 times a week for 4 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter (Online Version).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), physical therapy.

**Decision rationale:** The claimant sustained a work injury and May 2014 and continues to be treated for right shoulder pain. From November 2014 through January 2013 he completed 13 physical therapy treatments. When seen, he had ongoing weakness and instability with increasing pain while lifting. Authorization for additional physical therapy and up to 60 days rental of an interferential unit with purchased if effective was requested. Physical therapy for a rotator cuff tear could be expected to consist of up to 10 treatments over a, 8 week period of time. In this case, the claimant has already had in excess of that recommendation. In terms of physical therapy, patients are expected to continue active therapies at home. Compliance with a home exercise program would be expected and would not require continued skilled physical therapy oversight. Providing additional skilled physical therapy services would not reflect a fading of treatment frequency and prior physical therapy appears to have been relatively ineffective. The request was not medically necessary.

**Interferential (IF) Unit to right shoulder and supplies, 30-60 day rental and purchases 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 Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** The claimant sustained a work injury and May 2014 and continues to be treated for right shoulder pain. From November 2014 through January 2013 he completed 13 physical therapy treatments. When seen, he had ongoing weakness and instability with increasing pain while lifting. Authorization for additional physical therapy and up to 60 days rental of an interferential unit with purchased if effective was requested. A one month trial of use of an interferential stimulator is an option when conservative treatments fail to control pain adequately. Criteria for continued use of an interferential stimulation unit include evidence of increased functional improvement, less reported pain and evidence of medication reduction during a one month trial. If there was benefit, then purchase of a unit would be considered. Rental of a unit for up to 60 days is not cost effective and not medically necessary to determine its efficacy.