

Case Number:	CM15-0116936		
Date Assigned:	06/24/2015	Date of Injury:	07/20/2009
Decision Date:	07/23/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	06/16/2015

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: Maryland

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

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 58 year old female, who sustained an industrial/work injury on 7/20/09. She reported initial complaints of right shoulder pain. The injured worker was diagnosed as having rotator cuff tear of the right shoulder. Treatment to date has included medication, physical therapy, injection to shoulder on 10/16/13, and acupuncture. MRI results of the right shoulder were reported on 8/12/14. X-Rays results of the right shoulder and humerus were reported on 4/22/15. Currently, the injured worker complains of continued pain in the right shoulder, rated 2/10, unchanged from prior visit. Per the primary physician's progress report (PR-2) on 4/22/15, examination revealed pain was exacerbated by overhead activities. There is weakness in the internal and external rotation. X-rays demonstrated no increase in osteoarthritis. The requested treatments include IF (interferential) Unit; 30-60 days rental and purchase if effective (DOS: 4/22/15).

IMR ISSUES, DECISIONS AND RATIONALES

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

IF Unit; 30-60 days rental and purchase if effective (DOS: 4/22/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) - Page(s): 118-120.

Decision rationale: IF Unit; 30-60 days rental and purchase if effective (DOS: 4/22/15) is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that the interferential unit is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Additionally, the MTUS guidelines states that an interferential unit requires a one-month trial to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. The MTUS states that while not recommended as an isolated intervention an interferential unit can be considered if pain is ineffectively controlled due to diminished effectiveness of medications. The request cannot be certified as the trial period is recommended for one month and without evidence of reduced medication use, increased function and improved pain a purchase cannot be recommended therefore this request is not medically necessary.