

Case Number:	CM15-0127299		
Date Assigned:	07/14/2015	Date of Injury:	08/20/2013
Decision Date:	08/13/2015	UR Denial Date:	06/01/2015
Priority:	Standard	Application Received:	07/02/2015

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: California

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 female who sustained a work related injury August 20, 2013. While entering a building her foot became caught in an uneven rug, she stumbled forward and struck her right shoulder against a door. She experienced immediate pain. X-rays were taken of the right shoulder and she was treated with medication and physical therapy. A later MRI of the right shoulder revealed a rotator cuff tear and surgery was recommended. Prior to her surgery, she underwent a cholecystectomy June 2014, and is documented as "stopped breathing". The shoulder surgery was then postponed. According to a doctor's first report of injury, dated August 11, 2014, the injured worker presented for evaluation and treatment for an injured right shoulder. She was diagnosed with right shoulder periscapular strain with tendinitis; impingement syndrome and moderate acromioclavicular joint degenerative changes. Treatment plan included a prescription for Norco and a request for an interferential unit. According to a primary treating physician's progress report, dated May 8, 2015, the injured worker presented worsening right shoulder pain, rated 10. She reports her shoulder pops with a sharp pain on motion. Examination of the right shoulder revealed tenderness to palpation over the subacromial region, acromioclavicular joint with crepitus, and supraspinatus tendon. Impingement and cross arm tests are positive. Range of motion; flexion 140 degrees, extension 20 degrees, abduction 140 degrees, and adduction 25 degrees, and internal and external rotation 65 degrees. Diagnosis is documented as right shoulder periscapular strain, tendinitis and impingement. At issue, is the request for authorization for an interferential unit, home use with supplies.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) interferential unit- home use with supplies (electrodes, abtteries, lead wires):
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ICS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
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Decision rationale: Regarding the request for interferential unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then a one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation as outlined above. Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested interferential unit is not medically necessary.