

Case Number:	CM15-0128407		
Date Assigned:	07/15/2015	Date of Injury:	10/20/2014
Decision Date:	08/11/2015	UR Denial Date:	06/22/2015
Priority:	Standard	Application Received:	07/03/2015

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: Connecticut, California, Virginia
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 49-year-old female who sustained an industrial injury on 10/20/2014 resulting in right shoulder pain with limited range of motion, including numbness and tingling in the right arm and hand. She is diagnosed with cervical, lumbar, and right shoulder sprain and strain. Treatment has included right shoulder arthroscopic surgery, physical therapy from which she reported increased pain, and medication, which she says helps to manage pain level. The injured worker continues to present with upper right extremity pain and weakness. The treating physician's plan of care includes an inferential unit rental and purchase, and Tylenol Number 3. She is presently not working.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential (IF) unit and supplies 30-60 day rental and purchase: 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 stimulator Page(s): 118-120.

Decision rationale: The MTUS guidelines do not recommend interferential current stimulation (ICS) as an isolated intervention. There are no standardized protocols for the use of interferential therapy, and the evidence does not support clear value to treatment, and while not recommended as an isolated intervention, patient's should be selected for consideration only by meeting the following criteria: pain ineffectively controlled due to diminished effectiveness of medications or pain is ineffectively controlled with medications due to side effects. Additional criteria may include history of substance abuse or significant pain from postoperative conditions limiting the ability to perform exercise programs/physical therapy treatment, or unresponsiveness to conservative measures (repositioning, heat/ice, etc.). If the aforementioned criteria are met, consideration of a one-month trial may be appropriate to assess added benefit of treatment. The provided records do not discuss the criteria that would support consideration of ICS therapy, and therefore given the provided records, the request cannot be considered medically necessary.

Tylenol #3 qty #50: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: Chronic use of opioids is addressed thoroughly by the MTUS chronic pain guidelines and given the long history of pain in this patient since the initial date of injury, consideration of the MTUS Criteria for Use of Opioids in chronic pain is appropriate. Documentation of pain and functional improvement are critical components, along with documentation of adverse effects. While the MTUS does not specifically detail a set visit frequency for re-evaluation, recommended duration between visits is 1 to 6 months. In this case, the patient clearly warrants close monitoring and treatment, to include close follow up regarding improvement in pain/function; consideration of additional expertise in pain management should be considered if there is no evidence of improvement in the long term. More detailed consideration of long-term treatment goals for pain (specifically aimed at decreased need for opioids), and further elaboration on dosing expectations in this case would be valuable. Consideration of other pain treatment modalities and adjuvants is also recommended. Utilization Review reasonably non-certified the request as multiple opioids are not indicated in this case. Given the lack of clear evidence to support a need for the medication and the chronic risk of continued treatment, the request for Tylenol #3 is not considered medically necessary.