

Case Number:	CM15-0027857		
Date Assigned:	02/20/2015	Date of Injury:	05/16/2014
Decision Date:	04/02/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/13/2015

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 53 year old female, who sustained an industrial injury on 5/16/2014. The diagnoses have included sprains and strains of unspecified site of shoulder and upper arm, rotator cuff syndrome of shoulder and allied disorders, lateral epicondylitis, and medial epicondylitis. Treatment to date has included conservative measures. The PR2 report, dated 11/11/2014, was handwritten and somewhat illegible. Currently, the injured worker complains of continued pain in the left shoulder, rated 6-7/10. The injured worker was receiving self-procured physical therapy. Physical exam noted tenderness, positive impingement sign, positive crepitus, and decreased range of motion. Medication request included Ultram and Motrin for pain. Magnetic resonance imaging of the left shoulder, dated 5/07/2014, noted moderate to severe supraspinatus and infraspinatus tendinosis with superimposed small partial thickness tear and subacromial/subdeltoid and subcoracoid bursitis. Ultrasound of the bilateral shoulders, dated 11/04/2014, noted left partial thickness rotator cuff tear/supraspinatus/bursal surface, subacromial-subdeltoid bursitis, and left long head biceps tenosynovitis. On 2/04/2015, Utilization Review non-certified a request for interferential stimulator unit (purchase for left shoulder) and Thermophore moist heat pad (left shoulder), noting the lack of compliance with MTUS and Non-MTUS Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Stimulator Unit purchase for the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC).

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

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 (e.g., repositioning, heat/ice, etc.). If those criteria are met, then in 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 to allow for a trial. In light of the above issues, the currently requested interferential unit is not medically necessary.

Thermophore Moist Heat Pad purchase for the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

Decision rationale: Regarding the request for a Thermophore, CA MTUS and ACOEM state that patients at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. Within the documentation available for review, there is no clear rationale to support the use of a Thermophore rather than a simple low-tech heat pack as recommended by the CA MTUS and ACOEM. In light of the above issues, the currently requested Thermophore is not medically necessary.