MAXIMUS Federal Services

Case Number:	CM15-0037459		
Date Assigned:	03/20/2015	Date of Injury:	11/15/1982
Decision Date:	04/15/2015	UR Denial Date:	02/16/2015
Priority:	Standard	Application Received:	02/27/2015

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: New Jersey
Certification(s)/Specialty: Family Practice

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 (IW) is a 52 year old female, who sustained an industrial injury on 11/15/1982. On 01/14/2015, the worker complained of left shoulder, neck, right elbow and wrist pain. The injured worker was diagnosed as having cervical discopathy, status post left shoulder arthroscopy with subacromial arch decompression, status post right cubital release, and bilateral carpal tunnel syndrome/double crush syndrome. Treatment to date has included an MRI of the left shoulder and left shoulder arthroscopy with subacromial arch decompression, status post right cubital release (date not provided). Currently, the injured worker complains of left arm discomfort. Items requested are: 1 interferential unit, MR arthrogram of the left shoulder, 1 random urine drug screen, and 1 request to review medical records and be compensated for a narrative report that provides discussion.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 interferential unit: 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 Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The MTUS Chronic Pain Guidelines do not recommend interferential current stimulation (ICS) as an isolated intervention as there is no quality evidence. It may be considered as an adjunct if used in conjunction with recommended treatments, including return to work, exercise, and medications if these have not shown to provide significant improvements in function and pain relief, and has already been applied by the physician or physical therapist with evidence of effectiveness in the patient. Criteria for consideration would include if the patient's pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, if the patient has a history of substance abuse, if the patient has significant pain from postoperative conditions which limits the ability to perform exercise programs or physical therapy treatments, or if the patient was unresponsive to conservative measures (repositioning, heat/ice, etc.). A one month trial may be appropriate if one of these criteria are met as long as there is documented evidence of functional improvement and less pain and evidence of medication reduction during the trial period. Continuation of the ICS may only be continued if this documentation of effectiveness is provided. Also, a jacket for ICS should only be considered for those patients who cannot apply the pads alone or with the help of another available person, and this be documented. In the case of this worker, there was insufficient evidence submitted to warrant the request for an interferential unit. There was no specification as to whether or not it was a request for purchase or rental, but the lack of duration suggested that it was for purchase. There was no report of any previous successful trial with an interferential unit to help support a purchase of a similar unit for home use. Therefore, the request for "1 interferential unit" will be considered medically unnecessary based on the evidence found in the notes provided for review.

MR arthrogram of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The MTUS Guidelines state that special testing such as MRIs for most patients with shoulder problems are not needed unless a four to six-week period of conservative care and observation fails to improve symptoms and are not recommended earlier than this unless red flags are noted on history or examination that raise suspicion of a serious shoulder condition. Muscle strains do not warrant special testing. Even cases of impingement or muscle tears of the shoulder area should be treated conservatively first, and only when considering surgery would test such as MRI be helpful or warranted. After the initial course of conservative treatment over the 4-6 week period after the injury, MRI may be considered to help clarify the diagnosis in order to change the plan for reconditioning. The criteria for MRI of the shoulder include 1. Emergence of a red flag (intra-abdominal or cardiac problems presenting as shoulder problems), 2. physiologic evidence of tissue insult or neurovascular dysfunction such as cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the

presence of edema, cyanosis, or Reynaud's phenomenon, 3. failure to progress in a strengthening program intended to avoid surgery, and 4. Clarification of the anatomy prior to an invasive procedure such as in the case of a full thickness tear not responding to conservative treatment. When surgery is being considered for a specific anatomic defect (e.g., a full-thickness rotator cuff tear). Magnetic resonance imaging and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy although MRI is more sensitive and less specific. MR arthrography may be indicated in cases where labral tear is suspected or when there is a suspected retear of a rotator cuff after surgical repair. In the case of this worker, there was insufficient information provided to help support the MR arthrography of the left shoulder. Although surgery was performed on the left shoulder, there was no documented finding or symptom, which suggested a re-tear or labral tear, which might have indicated an MR arthrogram. Therefore, the MR arthrogram for the left shoulder will be considered medically unnecessary at this time.