

Case Number:	CM15-0063734		
Date Assigned:	04/09/2015	Date of Injury:	12/16/2014
Decision Date:	05/15/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	04/03/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 male, who sustained an industrial injury on 12/16/2014. He reported right shoulder pain while using a sledgehammer that jerked his shoulder forward. Diagnoses include right shoulder rotator cuff tear, full thickness, and right shoulder slap tear. Treatments to date include activity modification, medication therapy and physical therapy. Currently, he complained of right shoulder pain. On 2/24/15, the physical examination documented limited use of the right arm. The provider documented that surgery for rotator cuff repair was scheduled for 3/5/15. The plan of care included an IF unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-115.

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

Decision rationale: This patient is status post right shoulder rotator cuff repair on 03/05/15. The current request is for IF UNIT. The Request for Authorization is dated 02/26/15 and states that the request is for "Medical supplies: IF unit; Hot and Cold unit." The MTUS Chronic Pain Medical Treatment Guidelines, pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications. Pain is ineffectively controlled with medications due to side effects. History of substance abuse. Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment. Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.) If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. The medical records do not show a history of IF unit use. In this case, this patient recently underwent a right shoulder rotator cuff repair and MTUS guidelines support post-operative use of ICS; however, the current request does not specify the recommended duration of use. When an IF unit is indicated, a one-month trial is recommended first. The requested IF unit IS NOT medically necessary.