

Case Number:	CM15-0067867		
Date Assigned:	04/15/2015	Date of Injury:	12/09/2013
Decision Date:	05/20/2015	UR Denial Date:	03/31/2015
Priority:	Standard	Application Received:	04/09/2015

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, Hawaii
 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 46-year-old female, who sustained an industrial injury on 12/9/13. She reported left shoulder pain. The injured worker was diagnosed as having cervical pain, thoracic pain, left rotator cuff tear, left shoulder impingement syndrome and left shoulder tenosynovitis. Treatment to date has included oral medications including opioids, topical creams, activity restrictions and physical therapy. Currently, the injured worker complains of occasional mild upper mid back pain and occasional mild left shoulder pain, rated 2/10; improved since previous visit. Physical exam noted mild tenderness to palpation of mid thoracic spine and tenderness to palpation of supraspinatus area of left shoulder. All pain has improved since previous visit. The treatment plan included refills of oral medications, orthopedic consult and urine toxicology screening.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multi-stim unit plus supplies 5 month rental: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The patient presents with pain affecting the chest and left shoulder. The current request is for Multi-Stim unit plus supplies 5 month rental. The treating physician states, I am requesting authorization for this patient to obtain durable medical equipment in the form of muscle stimulator unit for five months for the left shoulder; and cold and heat pack for the left shoulder. (99B) The MTUS Guidelines states that neuromuscular electrical stimulation (NMES) devices are not recommended. There are no interventional trials suggesting benefit from NMES for chronic pain or postsurgical care. The MTUS Guidelines states that interferential current stimulation is indicated for patients with intolerability to medications, postoperative pain, history of substance abuse, etc. In this case, the treating physician has requested a rental amount, which exceeds the MTUS guidelines, and the patient is not in the post-operative timeframe and is responsive to conservative care. The current request is not medically necessary and the recommendation is for denial.

Heat/cold unit-purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder chapter, Continuous-flow Cryotherapy.

Decision rationale: The patient presents with pain affecting the chest and left shoulder. The current request is for Heat/Cold unit purchase. The treating physician states, I am requesting authorization for this patient to obtain durable medical equipment in the form of muscle stimulator unit for five months for the left shoulder; and cold and heat pack for the left shoulder. (99B) The ODG guidelines state, Recommended as an option after surgery, but not for non-surgical treatment. Postoperative use generally may be up to 7 days, including home use. In this case, the patient is not in the post-surgical timeframe requiring this medical device and the request is for purchase and not the recommended 7 days. The current request is not medically necessary and the recommendation is for denial.