

Case Number:	CM13-0011794		
Date Assigned:	09/25/2013	Date of Injury:	03/13/2013
Decision Date:	01/30/2014	UR Denial Date:	08/05/2013
Priority:	Standard	Application Received:	08/15/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine, has a subspecialty in Cardiology and is licensed to practice in Texas. 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 physician 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/services.

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 patient is a 61-year-old male who reported an injury on 03/13/2013. The patient is currently diagnosed with arthrofibrosis of the left elbow, paresthesia in the 4th and 5th digits of the left hand, left shoulder dislocation, left rotator cuff tendinitis, left rotator cuff tear, acromioclavicular degenerative joint disease, adhesive capsulitis in the left shoulder, pain in the left shoulder, and sprain and strain of the cervical spine. The patient was seen by [REDACTED] on 06/28/2013. Physical examination revealed no changes from a previous examination on 06/14/2013. Treatment recommendations were not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

H-Wave unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: The California MTUS Guidelines state H-Wave stimulation is not recommended as an isolated intervention, but a 1-month home based trial of H Wave stimulation may be considered as a non-invasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation. It should be used as an adjunct to a program of evidence-based functional restoration and only following failure of initially recommended conservative care,

including physical therapy, medications, and transcutaneous electrical nerve stimulation. As per the clinical notes submitted, there is no documentation of a previous failure to respond to conservative treatment. There is also no documentation of a concurrent request for a home electrical stimulation and the outcome of this intervention prior to consideration of an H-Wave unit. The medical necessity has not been established. Therefore, the request for H-wave unit is non-certified.

Continuous heat and cold machine for home use: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ACOEM Guidelines, 2nd Edition, 2008, pages 561-563; and ODG Shoulder, Continuous-flow cryotherapy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder Chapter, Continuous-flow cryotherapy.

Decision rationale: The Physician Reviewer's decision rationale: The Official Disability Guidelines state continuous flow cryotherapy is recommended as an option after surgery, but not for non-surgical treatment. There is no evidence of any recent surgical procedure noted to support the use of this durable medical equipment. The use of traditional hot and cold packs should be adequate for this clinical presentation. The medical necessity has not been established. Therefore, the request for continuous heat and cold machine for home use is non-certified

X-rays for shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, 2nd Edition, 2008, pages 561-563.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Radiography.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state that for most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. The Official Disability Guidelines state indications for imaging include acute shoulder trauma with a rule out fracture or dislocation or questionable bursitis. As per the clinical notes submitted, the patient underwent x-rays of the left shoulder in 03/2013. There is no evidence of instability or re-injury to substantiate the need for repeat x-rays. Based on the clinical information received, the request for x-rays for shoulder is non-certified.

X-rays for elbow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Elbow, Radiography.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 42-43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow Chapter, Radiography.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state that for most patients presenting with elbow problems, special studies are not needed unless a period of at least 4 to 6 weeks of conservative care and observation fails to improve symptoms. The Official Disability Guidelines state radiographs are required before other imaging studies and may be diagnostic for osteochondral fracture, osteochondritis desiccans, and osteocartilaginous intra-articular body. As per the clinical notes submitted, the patient underwent left elbow x-rays in 03/2013. There is no evidence of instability or re-injury to substantiate the need for repeat x-rays. The medical necessity has not been established. Therefore, the request for x-rays for elbow is non-certified.