

Case Number:	CM13-0022303		
Date Assigned:	11/13/2013	Date of Injury:	12/10/2009
Decision Date:	01/16/2014	UR Denial Date:	09/05/2013
Priority:	Standard	Application Received:	09/10/2013

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 Physical Medicine and Rehabilitation, and is licensed to practice in California. 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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 54 year old female who reported an injury on 12/10/09; the mechanism of injury was not provided. She failed an initial course of conservative treatment, and had a right arthroscopic decompression surgery on 6/19/12, followed by a course of physical therapy. The patient's diagnoses include impingement syndrome of the right shoulder, epicondylitis of the right elbow, and musculoligamentous sprain/strains to the cervical and lumbar spines. She continues to complain of chronic pain

IMR ISSUES, DECISIONS AND RATIONALES

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

The request for a motorized hot/cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines section on Shoulder - Continuous Flow Cryotherapy.

Decision rationale: The California MTUS and ACOEM guidelines did not specifically address the use of motorized hot/cold therapy, therefore, the Official Disability Guidelines (ODG) were used instead. ODG guidelines only recommend motorized cold therapy as an option in the post-

operative stage. There was nothing to suggest motorized or manual heat therapy was recommended for the shoulder, and there is no evidence in the medical records that indicates the need for a motorized hot/cold therapy unit. Therefore, the request for a motorized hot/cold therapy unit is non-certified.

The request for a pad for a water circulating hot/cold unit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary piece of durable medical equipment is not medically necessary, none of the associated services are medically necessary

The request for a neuromuscular stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Stimulation Page(s): 121.

Decision rationale: The California MTUS Guidelines do not recommend the use of neuromuscular electrical stimulation (NEMS) devices. There is no evidence based information to support the use of a NEMS unit in treating chronic pain. As such, the request for a neuromuscular stimulator is non-certified

The request for 18 pairs of electrodes: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary piece of durable medical equipment is not medically necessary, none of the associated services are medically necessary

The request for a Pain Care 3200 unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines section on Shoulder - Postoperative Pain Pumps.

Decision rationale: The California MTUS and ACOEM guidelines did not address the use of pain pumps, therefore the Official Disability Guidelines (ODG) were used instead. The Pain Care 3200 is a post-operative pain medication delivery system. According to the ODG, post-operative pain pumps are not recommended as there is insufficient evidence to suggest that pain pumps are any more effective than conventional measures. As such, the request for a Pain Care 3200 is non-certified.