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| Case Number: | CM13-0031136 | | |
| Date Assigned: | 12/04/2013 | Date of Injury: | 07/27/2013 |
| Decision Date: | 02/19/2014 | UR Denial Date: | 09/19/2013 |
| Priority: | Standard | Application Received: | 10/02/2013 |

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 Illinois and 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. 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 69 year old male who reported an injury on 07/27/2012 after he attempted to catch a falling display case causing injury to his left arm. The patient failed to respond to conservative treatments and ultimately underwent surgical intervention that resulted in adhesive capsulitis. The patient's most recent clinical evaluation revealed chronic pain of the right shoulder, poor function of the left shoulder with no overhead motion, and numbness in the left ulnar digits. The patient's diagnoses included status post left shoulder rotator cuff repair with residual pain, and cervical spine sprain/strain with radiculopathy, and bilateral ulnar/radial/median nerve neuropathy. The patient's treatment plan included continuation of medications and chiropractic care.

IMR ISSUES, DECISIONS AND RATIONALES

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

Solar Care FIR Heating System and FIR Heat Pad (Purchase) for Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 212-214.

Decision rationale: The requested Solar Care FIR Heating System and FIR Heat Pad (Purchase) for Left Shoulder is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has adhesive capsulitis. The American College of Occupational and Environmental Medicine recommends heat and cold application to provide symptom relief and promote participation in a home exercise program. The clinical documentation submitted for review does not provide any evidence that the patient is participating in a home exercise program. Additionally, there is no documentation that the patient has failed to respond to lesser levels of equipment. As such, the requested Solar Care FIR Heating System and FIR Heat Pad (Purchase) for Left Shoulder is not medically necessary or appropriate.

Chiropractic 3x4 weeks for the Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58.

Decision rationale: The requested Chiropractic 3x4 weeks for the Left Shoulder is not medically necessary or appropriate. The clinical documentation submitted for review does not provide any evidence that the patient has previously undergone chiropractic treatment for the left shoulder. The California Medical Treatment and Utilization Schedule recommends an initial trial of 6 chiropractic visits to establish the efficacy of this treatment modality. The requested 3 times a week for 4 weeks of chiropractic care exceeds this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond Guideline recommendations. As such, the requested Chiropractic 3x4 weeks for the Left Shoulder is not medically necessary or appropriate.