

Case Number:	CM13-0061700		
Date Assigned:	12/30/2013	Date of Injury:	08/08/2011
Decision Date:	05/22/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/05/2013

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. The expert reviewer is Board Certified in Physical Medicine & 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 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/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 injured worker reported an injury on 08/08/2011. The mechanism of injury was not provided. Current diagnoses include chronic pain, brachial plexus lesion, localized osteoarthritis of the shoulder region, pain in a joint of the shoulder region, and brachial neuritis/radiculitis. The injured worker was evaluated on 10/02/2013. The injured worker presented with symptoms of left sided thoracic outlet syndrome. Physical examination revealed guarding, limited mobility, generalized mild tenderness over the shoulder girdle, hypoesthesia to pinprick over the left ulnar nerve distribution, muscle spasm in the cervicobrachial and shoulder region, and restricted left shoulder range of motion. The injured worker has been previously treated with trigger point injections and a left scalene block. The injured worker has also received authorization for 6 sessions of physical therapy. Treatment recommendations included an H-Wave electrical stimulation unit and a follow-up with physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY (TOS SPECIFIC) X 12 SESSIONS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Physical Therapy

Decision rationale: The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The Official Disability Guidelines state medical treatment for thoracic outlet syndrome includes 14 visits over 6 weeks. As per the documentation submitted, the injured worker was previously authorized for 6 sessions of physical therapy. There is no documentation of a completion of the initial 6 sessions of physical therapy with evidence of objective functional improvement. The current request for 12 sessions of physical therapy, in addition to the previously authorized 6 sessions, exceeds Guideline recommendations. Based on the clinical information received, the request for Physical Therapy (TOS Specific) x 12 sessions is not medically necessary.

H- WAVE (PURCHASE): 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 may be considered as a non-invasive conservative option. H-Wave stimulation should be used as an adjunct to a program of evidence-based functional restoration and only following a failure of initially recommended conservative care. As per the documentation submitted, there is no documentation of a successful 1-month trial prior to the request for a unit purchase. There is also no evidence of a failure to respond to conservative treatment including physical therapy, medications, and TENS therapy. Therefore, the injured worker does not currently meet criteria for the requested durable medical equipment. As such, the request for H-Wave (Purchase) is not medically necessary.