

Case Number:	CM13-0065170		
Date Assigned:	01/03/2014	Date of Injury:	11/20/2007
Decision Date:	04/07/2014	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	12/12/2013

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 Orthopedic Surgery 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. 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 50-year-old female who reported an injury on 11/20/2007. The mechanism of injury involved a fall. The patient is diagnosed as status post right shoulder contusion, left shoulder periscapular strain, cervical strain, thoracic strain, lumbosacral strain, status post right knee contusion, right elbow sprain, right knee sprain, emotional complaints of stress and depression, gastrointestinal upset and a history of fibromyalgia syndrome. The patient was seen by [REDACTED] on 09/11/2013. The patient reported persistent pain over multiple areas of the body. Physical examination revealed tenderness to palpation with muscle guarding of the paraspinal musculature, decreased range of motion, positive Yeoman's and Gaenslen's testing on the right, tenderness with muscle guarding over the upper trapezius muscles and periscapular regions, tenderness to palpation over the subacromial region, positive impingement and cross arm testing, diminished range of motion, positive Finkelstein's testing, tenderness to palpation over the medial joint line, positive patellofemoral compression and grind testing and intact sensation. Treatment recommendations included a home electrical stimulation unit and a heating pad.

IMR ISSUES, DECISIONS AND RATIONALES

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

SCAPULA STABILIZER: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 205.

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS/ACOEM Practice Guidelines state that patients with shoulder disorders tend to have stiffness followed by weakness and atrophy. If indicated, the joint can be kept at rest in a sling. As per the documentation submitted, there is no evidence of a significant instability of the shoulder. The medical necessity for the requested durable medical equipment has not been established. Therefore, the request is non-certified.

SPINE STABILIZER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 300.

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS/ACOEM Practice Guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. As per the documentation submitted, the patient's injury was greater than 6 years ago to date. Therefore, the patient is no longer within the acute phase of treatment. There is no documentation of significant instability. Based on the clinical information received, the request is non-certified.

MOIST HEATING PAD: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 301.

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS/ACOEM Practice Guidelines state that physical modalities have no proven efficacy in treating acute low back symptoms. At home local applications of heat or cold are as effective as those performed by therapists. As per the documentation submitted, there is no evidence of a contraindication to at home local applications of heat or cold as opposed to a heating pad. The medical necessity for the requested equipment has not been established. Therefore, the request is non-certified.

TENS UNIT AND SUPPLIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

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

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS Guidelines state that transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month, home-based trial may be considered as a noninvasive conservative option. There is no documentation of this patient's active participation in an exercise program. There was no evidence of a failure to respond to other appropriate pain modalities. There was no evidence of a successful 1 month trial period with a TENS unit prior to the request for a purchase. There was also no treatment plan including the specific short and long-term goals of treatment with the unit submitted for review. Based on the clinical information received, the request is non-certified.

HEEL STABILIZER: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Foot and Ankle

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 369-371.

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS/ACOEM Practice Guidelines state that elevation and a brief period of nonweightbearing may be effective for pain management and resolution of swelling with regards to the ankle and foot. Rigid orthotics are indicated for plantar fasciitis and metatarsalgia. Night splints are indicated for plantar fasciitis. There is no documentation of a significant musculoskeletal deficit with regard to the bilateral lower extremities. The medical necessity for the requested equipment has not been established. Therefore, the request is non-certified.

LUMBAR ORTHOSIS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS/ACOEM Practice Guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. As per the documentation submitted, the patient's injury was greater than 6 years ago to date. Therefore, the patient is no longer within

the acute phase of treatment. There is no documentation of significant instability. Based on the clinical information received, the request is non-certified.

CERVICAL PILLOW AND PILLOW CASE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Pillow

Decision rationale: The Physician Reviewer's decision rationale: The Official Disability Guidelines recommend the use of a neck support pillow while sleeping, in conjunction with daily exercise. There is no documentation of this patient's active participation in an exercise program. Based on the clinical information received, the request is non-certified.