

Case Number:	CM13-0068283		
Date Assigned:	01/03/2014	Date of Injury:	03/23/2011
Decision Date:	06/04/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/19/2013

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 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 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 is a 37-year-old female who reported an injury on 03/23/2011. The mechanism of injury was not provided. The documentation of 10/18/2013 revealed the injured worker had been utilizing medications. The physical examination of the cervical spine revealed tenderness to palpation of the paracervical, trapezius and supraspinatus muscles on the right. The injured worker had a positive cervical compression test. The patient had tenderness to palpation over the SC joint, AC joint, supraspinatus, infraspinatus and greater tuberosity. The injured worker had decreased range of motion of the right shoulder. The Codman's test was positive. The injured worker had a shoulder abduction sign that was positive. There was a sign of impingement and the Neer test and Hawkins test were positive. The diagnoses included cervical myospasm, cervical disc herniation without myelopathy, right shoulder adhesive capsulitis, right shoulder subacromial and subdeltoid bursitis, right shoulder impingement syndrome, and right shoulder rotator cuff syndrome. The treatment plan was for the injured worker to stay active and the injured worker was prescribed a course of 24 sessions of physical therapy/modality therapy, an orthopedic consultation for the right shoulder, a urinalysis for toxicology and medication compliance, use of topical compounds, a CT of the right shoulder, and an ultrasound stimulator for home use.

IMR ISSUES, DECISIONS AND RATIONALES

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

CONDUCTIVE GEL: 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 item is not medically necessary, none of the associated items are medically necessary.

ULTRASOUND STIMULATION PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ULTRASOUND, THERAPEUTIC Page(s): 123.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ULTRASOUND, THERAPEUTIC Page(s): 123.

Decision rationale: The California MTUS Guidelines indicate that therapeutic ultrasound use is not recommended. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for the ultrasound stimulation purchase is not medically necessary.