

Case Number:	CM13-0069367		
Date Assigned:	01/03/2014	Date of Injury:	07/13/2012
Decision Date:	04/24/2014	UR Denial Date:	12/09/2013
Priority:	Standard	Application Received:	12/20/2013

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 and Rehabilitation, has a subspecialty in Sports Medicine, and is licensed to practice in New York 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 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 patient is a 64-year-old female who reported an injury on 7/13/12. The mechanism of injury involved a fall. The patient is diagnosed with joint pain, and pain in the arm. The patient was seen by [REDACTED] on 11/1/13. The patient reported persistent right shoulder pain. Physical examination revealed decreased and painful range of motion of the right shoulder. Treatment recommendations at that time included an MRI of the right shoulder, multi-stimulator unit, heat and cold pack for the right shoulder, work conditioning, a urine toxicology screen, and continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

A SOLACE MULTI STIM UNIT FOR 5 MONTHS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116, 118-119, 121.

Decision rationale: The California MTUS guidelines state that transcutaneous electrotherapy is not recommended as a primary treatment modality, but a one-month trial can be considered as a

non-invasive conservative option. Neuromuscular electrical stimulation is not recommended. Interferential current stimulation is also not recommended as an isolated intervention. As per the documentation submitted, there is no evidence of a successful one month trial prior to the request for a five month rental. Based on the clinical information received, the request is non-certified.

ELECTRICAL STIMULATOR SUPPLIES, 2 LEADS PER MONTH FOR 5 MONTHS:
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 procedure is not medically necessary, none of the associated services are medically necessary.

2 LEAD WIRES: 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 procedure is not medically necessary, none of the associated services are medically necessary.

AN ADAPTOR: 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 procedure is not medically necessary, none of the associated services are medically necessary.

A 6-WEEK RENTAL OF A CONTRAST AQUA THERAPY WATER CIRCULATING UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 555-556. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: The California MTUS/ACOEM guidelines state that physical modalities are not supported by high quality medical studies. At-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. The Official Disability Guidelines state that continuous-flow cryotherapy is recommended as an option after surgery, but not for non-surgical treatment. As per the documentation submitted, the patient's physical examination only revealed decreased and painful range of motion of the right shoulder. There is no mention of a contraindication to at-home local applications of heat or cold as opposed to a circulating unit. Based on the clinical information received, the request is non-certified.

6-WEEK RENTAL OF A CONTRAST AQUA THERAPY WATER CIRCULATING

PAD: 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 procedure is not medically necessary, none of the associated services are medically necessary.

6-WEEK RENTAL OF A CONTRAST AQUA THERAPY SHOULDER WRAP: 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 procedure is not medically necessary, none of the associated services are medically necessary.

THE FEE FOR INSTALLATION: 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 procedure is not medically necessary, none of the associated services are medically necessary.