

Case Number:	CM14-0103197		
Date Assigned:	07/30/2014	Date of Injury:	11/29/2012
Decision Date:	10/03/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/03/2014

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 Internal Medicine 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 is a 66 year old female who reported an injury to her right upper extremity. The clinical note dated 12/13/12 indicates the injured worker stated the injured worker nearly struck a coworker when she fell forward onto an outstretched right upper extremity. The injured worker reported immediate pain as well as a deformity in the arm. The injured worker was transported to the emergency room where she was placed in a fracture brace. The injured worker continued with complaints of moderate sharp pain at the arm which was aggravated with all movements. The injured worker stated the pain was affecting her sleep hygiene. The injured worker stated that she is able to sleep in an upright position. Numbness was identified in the thumb as well. The clinical note dated 05/20/13 indicates the injured worker continuing with range of motion limitations at the right shoulder. Minimal tenderness was identified over the humerus. The injured worker was able to demonstrate 120 degrees of flexion, 80 degrees of abduction, as well as 60 degrees of external rotation. X-rays of the humerus revealed evidence of a callous formation. However, the fracture had not fully consolidated. The clinical note dated 08/14/13 indicates the injured worker continuing to demonstrate range of motion improvements to include 150 degrees of flexion and 55 degrees of external rotation. The injured worker was being recommended to initiate physical therapy at that time. The independent medical exam dated 05/28/14 indicates the injured worker having developed frozen shoulder. The note does indicate the injured worker having completed 12 weeks of physical therapy and was subsequently discharged. Tenderness was identified throughout the trapezius region. Significant range of motion deficits were identified throughout the right shoulder to include 90 degrees of abduction. The injured worker as identified as having a positive impingement and an Apley's scratch test.

IMR ISSUES, DECISIONS AND RATIONALES

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

Optimum Shoulder Rehab Kit Purchase: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Worker's Compensation

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Home exercise kits

Decision rationale: The request for a shoulder rehab purchase is medically necessary. The documentation indicates the injured worker continuing with significant range of motion deficits throughout the right shoulder. The clinical notes indicate the injured worker having undergone a course of physical therapy addressing the right shoulder complaints. Given the progression to a home exercise program, it would be reasonable for the injured worker to undergo in-home treatment with a rehab kit in order to increase functional capabilities to include range of motion as well as strength. Given the ongoing range of motion deficits associated at the right shoulder, this request is reasonable.

Solar Care Infrared Heating Pad Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Worker's Compensation

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

Decision rationale: The request for a solar care infrared heating pad purchase is not medically necessary. The documentation indicates the injured worker complaining of right shoulder pain. The use of heat is indicated at affected joints. However, the local at home application of heat is recommended over commercial products as currently no high quality studies have been published in peer reviewed literature supporting the use of commercial products over in-home use of the application of heat. Therefore, this request is not indicated as medically necessary.

X-Force Stimulator X90 Day Trial with 3 Months Supply (Garment Electrode): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: The request for an X-force stimulator is not medically necessary. The use of electrical stimulation is generally utilized as part of a rehabilitation program following a stroke. No high quality studies have been published in peer reviewed literature supporting the use of electrical stimulation devices for the use of chronic pain. No information was submitted regarding the injured worker's stroke history. Given these factors, this request is not indicated as medically necessary.