

Case Number:	CM14-0105044		
Date Assigned:	07/30/2014	Date of Injury:	10/01/2012
Decision Date:	09/26/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	07/07/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 48 year old female was reportedly injured on October 1, 2012. The mechanism of injury is undisclosed. The most recent progress note, dated July 28, 2014, indicated that there were ongoing complaints of wrist and upper extremity pains. The physical examination demonstrated tenderness over the right wrist, with a full range of motion to flexion, extension, and keloid scar was noted. Diagnostic imaging studies were not referenced. Previous treatment included open reduction and internal fixation of an upper extremity fracture, multiple medications, physical therapy, and pain management interventions. A request was made for shoulder rehabilitation kit and an interferential (IF) unit one month rental with supplies and was denied in the preauthorization process on June 6, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

SHOULDER REHAB KIT PURCHASE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201.

Decision rationale: The records, presented for review, indicate that this is a wrist injury. There is a full range of motion of the wrist. A keloid scar has formed, and there is some mild tenderness. A home exercise protocol has been outlined. Therefore, simple exercises do not require a specific set of durable medical equipment. As such, when noting the physical therapy parameters outlined in the American College of Occupational and Environmental Medicine (ACOEM) guidelines and by the physical examination reported, there is no medical necessity established for this device.

IF UNIT, ONE MONTH RENTAL WITH SUPPLIES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

Decision rationale: As noted in the Medical Treatment Utilization Schedule (MTUS) guidelines, there is no support for interferential therapy as an isolated intervention. Furthermore, when considering the range of motion of the wrist reported and the physical examination, there is no indication presented for the medical necessity of this device. Therefore, when combining these two factors, this is not medically necessary.