

Case Number:	CM14-0152709		
Date Assigned:	09/22/2014	Date of Injury:	06/16/2014
Decision Date:	10/22/2014	UR Denial Date:	08/21/2014
Priority:	Standard	Application Received:	09/18/2014

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 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:

This 49 year-old patient sustained an injury on 6/16/14 from moving a wheelchair while employed by [REDACTED]. Request(s) under consideration include [REDACTED] heating system. Diagnoses include s/p right elbow surgery on 7/8/14; cervical, lumbar sprain/strain; bilateral shoulder, left elbow, bilateral wrist/hand, bilateral knee, ankle sprain/strain; anxiety, depression, sleep disorder, GERD, and headaches. The patient continues to treat for ongoing right shoulder and right elbow pain. Report of 8/1/14 from the provider noted the patient has been TTD since 6/19/14. The patient has multiple complaints to include stress, anxiety, depression, heartburns, headaches, difficulty sleeping, neck pain with associated numbness and tingling in upper extremities; bilateral shoulder, arms, elbow, wrists, hand pain; lumbar spine, bilateral knee, and ankle/feet pain. Exam showed tenderness, positive orthopedic testing (Spurling, SLR), limited range, and unable to perform most exam on right extremity from cast; sensory of left upper extremity and bilateral lower extremities were intact with normal gait, heel-toe walking with intact DTRs and motor strength of left upper and bilateral lower extremities. The request(s) for [REDACTED] heating system was non-certified on 8/21/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

[REDACTED] heating system: 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)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-220. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder/ arm, Diathermy/ heat therapy, pages 911

Decision rationale: This 49 year-old patient sustained an injury on 6/16/14 from moving a wheelchair while employed by [REDACTED]. Request(s) under consideration include [REDACTED] heating system. Diagnoses include s/p right elbow surgery on 7/8/14; cervical, lumbar sprain/strain; bilateral shoulder, left elbow, bilateral wrist/hand, bilateral knee, ankle sprain/strain; anxiety, depression, sleep disorder, GERD, and headaches. The patient continues to treat for ongoing right shoulder and right elbow pain. Report of 8/1/14 from the provider noted the patient has been TTD since 6/19/14. The patient has multiple complaints to include stress, anxiety, depression, heartburns, headaches, difficulty sleeping, neck pain with associated numbness and tingling in upper extremities; bilateral shoulder, arms, elbow, wrists, hand pain; lumbar spine, bilateral knee, and ankle/feet pain. Exam showed tenderness, positive orthopedic testing (Spurling, SLR), limited range, and unable to perform most exam on right extremity from cast; sensory of left upper extremity and bilateral lower extremities were intact with normal gait, heel-toe walking with intact DTRs and motor strength of left upper and bilateral lower extremities. The request(s) for [REDACTED] heating system was non-certified on 8/21/14. Regarding Hot/Cold therapy, guidelines state it is recommended as an option after surgery, but not for nonsurgical treatment. The patient is s/p right elbow surgery; however, is currently placed in a cast, not conducive to a heating system. The request for authorization does not provide supporting documentation for purchase beyond the guidelines criteria. There is no documentation that establishes medical necessity or that what is requested is medically reasonable outside recommendations of the guidelines which note local application of heat or cold is as effective as those performed by therapists and high tech devices have not demonstrated superior efficacy over the use of traditional non-motorized heating pad modalities. MTUS Guidelines is silent on specific use of hot/cold compression therapy, but does recommend standard hot/cold pack with exercise. The [REDACTED] heating system is not medically necessary and appropriate.