

Case Number:	CM14-0020500		
Date Assigned:	04/30/2014	Date of Injury:	10/12/1993
Decision Date:	07/08/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/19/2014

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 & 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:

The injured worker is a 43-year-old male who reported an injury on 10/12/1993. The mechanism of injury was not stated. Current diagnoses include chronic regional pain syndrome, status post left TKR, rule out right radio carpal degenerative joint disease and neuropathic pain. The injured worker was evaluated on 01/07/2014. The injured worker reported persistent left hip pain as well as low back pain. The injured worker also reported residual bilateral wrist pain and numbness. Physical examination revealed tenderness with mild swelling of the right volar wrist, occasional crepitus with passive range of motion, positive Tinel's testing, full elbow range of motion, left lateral epicondyle tenderness, decreased lumbar range of motion, lumbar paraspinal spasm, left SI joint tenderness, positive straight leg raising bilaterally, painful range of motion of the left hip, left buttock tenderness, gluteal and hip soft tissue myofascial tightness, groin tenderness, full left knee range of motion with crepitus, and positive patellar compression and apprehension testing. Treatment recommendations at that time included a prescription for a Theracane.

IMR ISSUES, DECISIONS AND RATIONALES

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

DURABLE MEDICAL EQUIPMENT (DME): THERACANE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Durable Medical Equipment.

Decision rationale: Official Disability Guidelines state durable medical equipment is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. The term durable medical equipment is defined as equipment which can withstand repeated use, could normally be rented, and is used by successive patients. As per the documentation submitted, the injured worker is greater than 20 years post injury. There is no clear rationale as to how the requested durable medical equipment will result in long term benefit or functional improvement. Based on the clinical information received and the Official Disability Guidelines, the requested is not medically necessary.