

Case Number:	CM14-0025126		
Date Assigned:	06/11/2014	Date of Injury:	03/12/2011
Decision Date:	07/15/2014	UR Denial Date:	02/11/2014
Priority:	Standard	Application Received:	02/27/2014

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, has a subspecialty in Pain Medicine and is licensed to practice in 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 injured worker is a 67-year-old female who reported an injury on 03/12/2011. The mechanism of injury involved a fall. Current diagnoses include a medial meniscus tear, cervical disc disease with radiculopathy, lumbar disc syndrome with radiculopathy, right shoulder status post rotator cuff repair, and subacromial bursitis with adhesive capsulitis. The injured worker was evaluated on 11/26/2013. Physical examination revealed tenderness to palpation, limited cervical range of motion, tenderness to palpation of the right shoulder, limited range of motion of the right shoulder, tenderness to palpation of the lumbar spine, and normal lordosis. Treatment recommendations at that time included an orthopedic consultation, physical therapy, chiropractic treatment, a urine toxicology screening, and continuation of topical medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

MULTI-STIM UNIT PLUS SUPPLIES: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-117.

Decision rationale: California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality but 1 month home based trial may be considered as a noninvasive conservative option. There should be evidence that other appropriate pain modalities have been tried and failed. As per the documentation submitted, there is no indication of a failure to respond to conservative treatment. There is also no documentation of a successful 1 month trial prior to the request for a unit purchase. As such, the request is non-certified.

AQUA RELIEF SYSTEM: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints.

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. There is no documentation of a clear description of the requested device. Therefore, the medical necessity has not been established. As such, the request is non-certified.

HOME EXERCISE KIT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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, Home exercise kit.

Decision rationale: Official Disability Guidelines state home exercise kits are recommended as an option where home exercise programs are recommended. As per the documentation submitted, the injured worker has participated in a course of physical therapy. There is no indication that a home exercise program is ineffective. As the medical necessity has not been established, the current request is non-certified.

ASPEN SUMMIT BACK SUPPORT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: California MTUS/ACOEM Practice Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. As per the

documentation submitted, the injured worker's physical examination of the lumbar spine does not reveal significant instability. Therefore, the medical necessity for the requested durable medical equipment has not been established. As such, the request is non-certified.