

Case Number:	CM14-0026917		
Date Assigned:	06/13/2014	Date of Injury:	03/12/2007
Decision Date:	10/01/2014	UR Denial Date:	02/05/2014
Priority:	Standard	Application Received:	03/03/2014

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 Orthopedic Surgery 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 employee is a 59-year-old male injured on 3/12/2007. The mechanism of injury was noted as a twisting injury to the left shoulder. The most recent progress note indicates that there are ongoing complaints of chronic left shoulder pain. The physical examination demonstrated a decreased range of motion. Diagnostic imaging studies included left shoulder radiographs, which revealed postsurgical changes to include a large rotator cuff tear, subacromial decompression and distal clavicle resection. Previous treatment included medications to include NSAIDs, muscle relaxers, physical therapy and arthroscopic surgery with an associated manipulation under anesthesia. A request had been made for interferential current stimulation, associated supplies, a cold therapy unit and attendant materials and was not certified in the pre-authorization process on 2/5/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

**Interferential Current Stimulation IF 11 monthly supplies for rent or for purchase
Bilateral Knees:** Upheld

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

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

Decision rationale: The medical documentation reviewed discussed a male patient with a left shoulder injury dated 3/12/2007. There were no reports provided regarding his current bilateral knee condition. Based on available medical records submitted for review and due to lack of documentation stating cause, limitation of function and rationale, the treatment request for interferential current stimulation with monthly supplies for rent and/or purchase for bilateral knees is not medically necessary.

Cold Therapy Unit for rent or for purchase-Bilateral Knees: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

Decision rationale: There is no documentation supporting the current condition, physical exam, or objective narrative why such a device is clinically indicated. As listed above, based on the submitted medical records, this treatment request for cold therapy for bilateral knees is not medically necessary.

Hot Cold Pad for rent or for purchase-Bilateral Knees: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

Decision rationale: Hot and cold packs are allowable durable medical equipment to be prescribed to patients who have undergone recent surgery or are scheduled for surgery. When noting the date of surgery and the limited clinical findings, there is insufficient data presented to support this request. The treatment request is deemed to be not medically necessary.

ASSY strap for rent or for purchase-Bilateral Knees: 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 The Merck Manual, Knee Pain. Knee Straps.

Decision rationale: CA MTUS and ODG guidelines do not address this issue. Therefore additional medical references were used for citation. Based on the submitted medical records provided for review, the treatment request for bilateral knee assay strap is not medically necessary. There is insufficient documentation from the treating physician for justification and need of this equipment. Therefore this request is not medically necessary.