

Case Number:	CM14-0046501		
Date Assigned:	07/02/2014	Date of Injury:	08/17/2008
Decision Date:	08/27/2014	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/15/2014

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 Family Medicine and is licensed to practice in Utah. 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 patient is a 56 year-old female with an injury date of 8/17/2008. The mechanism of injury is not stated in the clinical notes. The patient has been diagnosed with tenosynovitis of the hand or wrist, radial styloid tenosynovitis, carpal tunnel syndrome, lesion of ulnar nerve, rotator cuff syndrome, lumbar strain and sprain, sacroiliac ligament pain, knee pain, and ankle pain. The patient's treatments have included: surgery (subacromial decompression, distal clavicle resection and rotator cuff debridement/repair), acupuncture, trigger point injections, home exercise program, bracing, imaging studies, an Electronic Muscle Stimulator Unit (EMS), and medications. Many of the clinical documents are handwritten and illegible. The physical exam findings dated 2/20/2014 show right wrist/thumb with TTP over the 1st radial, right knee with swelling, and PPT limited flex ROM. The patient's medications have included, but are not limited to Lidoderm Patches and Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurological consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Chapter 7-Independent Medical Examination and Consultations.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 22. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM): Independent Medical Examinations and Consultations, chapter 7.

Decision rationale: MTUS Treatment Guidelines were reviewed in regards to this specific case. The request is for a Neurological Consultation. MTUS Guidelines state "consultation is indicated when there are red flag findings. Also, to aid in the diagnosis, prognosis, therapeutic management, and determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work." The clinical documents lack documentation that state that the patient has neurological defects, which would warrant a referral to neurology. According to the clinical documentation provided and current MTUS guidelines; Neurological consultation is not medically necessary to the patient at this time.

Replacement of SurgiStim unit/OS4 unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

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

Decision rationale: MTUS Treatment Guidelines were reviewed in regards to this specific case. The request is for a replacement SurgiStim Unit. MTUS Guidelines state "it is not recommended as a primary treatment modality; it is also recommended that a one month trial, be attempted." The clinical documents lack documentation for indication of the multi stimulator device. There is also no documentation that currently reports the outcome of the current machine that the patient has. According to the clinical documentation provided and current MTUS Guidelines; replacement of SurgiStim Unit/OS4 Unit is not medically necessary to the patient at this time.

Home Care Assist: six hours per day, seven days per week for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Page(s): 51.

Decision rationale: MTUS Treatment Guidelines were reviewed in regards to this specific case. The request is for home care assistant for six hours per day, seven days per week for six weeks. MTUS Guidelines state "home health services - recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed." There is lack of

documentation that state the patient is homebound. Also, the requested amount of hours exceeds the guidelines. According to the clinical documentation provided and current MTUS Guidelines; home care assistant for six hours per day, seven days per week for six weeks is not medically necessary to the patient at this time.