

Case Number:	CM14-0176338		
Date Assigned:	12/11/2014	Date of Injury:	06/27/2012
Decision Date:	01/21/2015	UR Denial Date:	09/24/2014
Priority:	Standard	Application Received:	10/24/2014

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 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 is a 40 year old male patient who sustained a work related injury on 6/27/12. Patient sustained the injury in a motor vehicle accident. The current diagnoses include left shoulder non-calcifying tendinitis; left hip trochanteric tendinitis; chronic low back pain; status post arthroscopic surgical intervention to the right knee; strain of back, low back, left shoulder, left hip, cervical spine. Per the doctor's note dated 8/20/14, patient has complaints of left shoulder and left hip pain. Per the doctor's note dated 6/14/14 patient had complaints of left shoulder pain that radiates to neck and elbow; low back pain and left hip. Physical examination revealed limited range of motion, 5/5 strength, normal sensation and reflexes, normal gait, positive impingement sign, tenderness on palpation. The current medication lists include Relafen, Prilosec, Ultram, and Prilosec. The patient has had MRI of the low back on 9/26/2013 that revealed mild spondylosis at L3-L4 and L4-L5; MRI of the left Shoulder on 11/21/2013 that revealed chronic traumatic bursitis; MRI of the Cervical Spine 11/21/2013 that revealed loss of cervical lordosis and no disc degeneration or herniation. The patient's surgical history includes right knee surgery on 3/28/14. The patient reported increased pain to the shoulder since starting ESWT. The patient has received an unspecified number of the PT visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home Exercise Kit Left Shoulder: 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) Shoulder (updated 10/31/14) Home exercise kits

Decision rationale: ACOEM/ CA MTUS do not address this request. Therefore ODG used. Any contraindication to a simple home exercise program without specialized equipment is not specified in the records provided. The rationale for the need of specialized equipment is not specified in the records provided. Response to prior conservative therapy is not specified in the records provided. The medical necessity of the request for Home Exercise Kit Left Shoulder is not fully established in this patient.

Vital Wrap Left Shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back (updated 08/04/14), Heat/cold applications

Decision rationale: Per the cited guidelines "Patients' at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. Rationale for not using simple hot/cold packs versus the use of this DME is not specified in the records provided. Per the cited guidelines, "Insufficient testing exists to determine the effectiveness (if any) of heat/cold applications in treating mechanical neck disorders " A recent detailed clinical evaluation note of treating physician was not specified in the records. Any surgery or procedures related to this injury were not specified in the records provided. Any operative note was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury Detailed response to previous conservative therapy was not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. The medical necessity of the request for Vital Wrap Left Shoulder is not fully established in this patient.