

Case Number:	CM14-0026256		
Date Assigned:	06/13/2014	Date of Injury:	03/23/2011
Decision Date:	02/25/2015	UR Denial Date:	02/18/2014
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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabn

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 39 year old female with an injury date on 03/23/2011. Based on the 01/18/2014 progress report provided by the treating physician, the diagnoses are: 1. Cervical disc herniation without myelopathy 2. Right shoulder subcromial and subdeltoid bursitis 3. Right shoulder adhesive capsulitis 4. Right shoulder impingement syndrome 5. Partial tear of supraspinatus tendon. According to this report, the patient complains of "having problem with her shoulder. She still has pain. She also has neck pain on the right side. In addition, also now she has been complaint of right elbow pain." Per treating physician "the patient has been taking ibuprofen and gabapentin and is helping better than the tramadol." Physical exam reveals tenderness at the cervical paraspinal muscles, supraspinatus muscles, trapezius muscle, SC and AC joint of the shoulder, infraspinatus, and greater tuberosity. Cervical spine and right shoulder range of motion is restricted. Cervical compression test, Shoulder abduction sign, Impingement, Neer's, and Hawkins test are positive. The treatment plan is to continue with course of 24 sessions of chiropractic, physical therapy, 6 course of acupuncture treatment, UDS, continue with topical cream, and recommend ultrasound stim unit for home use. The patient's work status "to remain off work until eight weeks." There were no other significant findings noted on this report. The utilization review denied the request for conductive gel and Ultrasound Stimulation Purchase on 02/18/2014 based on the MTUS/ODG guidelines. The requesting physician provided treatment reports from 09/06/2013 to 01/18/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Conductive Gel: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 8. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter online for DME.

Decision rationale: According to the 01/18/2014 report, this patient presents with right shoulder pain. The current request is for Conductive Gel. Under durable medical equipment section in ODG Guidelines, durable medical equipment is defined as an equipment that is primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury. In this case, the requested conductive gel is not medically necessary as the request for the Ultrasound Stimulation is not support by the guidelines for this case. Therefore, this request IS NOT medically necessary.

Ultrasound Stimulation Purchase: 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 chapter: Ultrasound, therapeutic.

Decision rationale: According to the 01/18/2014 report, this patient presents with right shoulder pain. The current request is for Ultrasound Stimulation Purchase. The MTUS and ACOEM guidelines do not discuss ultrasound. However ODG, Shoulder chapter under Ultrasound, therapeutic states "Recommended as indicated below. The evidence on therapeutic ultrasound for shoulder problems is mixed. (Philadelphia, 2001) Ultrasound provided clinically important pain relief relative to controls for patients with calcific tendonitis of the shoulder in the short term. (Ebenbichler-NEJM, 1999) But the evidence does not support use of ultrasound for other conditions of the shoulder. In reviewing the medical reports provided, the treating physician does not indicate that the patient has "calcific tendonitis of the shoulder." Furthermore, ODG guideline support the use therapeutic Ultrasound for short-term use only and not for purchase. Therefore, this request is not medically necessary.