MAXIMUS Federal Services

Case Number:	CM14-0098651		
Date Assigned:	07/28/2014	Date of Injury:	01/20/2013
Decision Date:	01/28/2015	UR Denial Date:	05/28/2014
Priority:	Standard	Application Received:	06/26/2014

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 Rehab, has a subspecialty in Interventional spine 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 patient is a 35 year old female with an injury date of 01/20/13. Based on the 03/18/14 progress report provided by treating physician, the patient complains of postsurgical right shoulder pain rated 9/10 with radiation to the right upper extremity and associated numbness, tingling, burning sensation and swelling. Physical examination on 03/18/14 and 04/15/14 revealed well-healed incisions with no infection, sutures removed and steristrips applied. Slight edema noted over the postoperative right shoulder. Medications include Anaprox and Ultracet. Per treating physician report dated 04/15/14, patient's pain is rated 7-8/10 and she is attending physical therapy two times a week. Per Request for Authorization form addendum dated 03/18/14, treating physician states "FIR Heat Pad, portable, use daily as needed. Recommended 6-8 hours per day. Patient would benefit from a purchase of this item." X-Force unit "is being prescribed as an adjunct to conservative treatment as part of the customized functional restoration program that is specifically designed for this patient."Diagnosis 03/28/14- right shoulder sprain/strain- right shoulder tendinitis- right shoulder rotator cuff syndrome- right elbow sprain/strain- rule out right elbow epicondylitisDiagnosis 03/18/14, 04/15/14- status post right shoulder arthroscopy with distal clavicle resection and rotator cuff repair on 03/12/14The utilization review determination being challenged is dated 05/28/14. Treatment reports were provided from 11/27/13 - 04/15/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective (DOS: 03/18/2014) X-Force stim unit purchase and 3 months of supplies, conductive garment times 2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous Electrical Nerve Stimulation) Page(s): 114-116.

Decision rationale: The patient presents with postsurgical right shoulder pain rated 9/10 with radiation to the right upper extremity and associated numbness, tingling, burning sensation and swelling. The request is Retrospective (DOS: 03/18/2014) X-Force stim unit purchase and 3 months of supplies, conductive garment times 2. The patient is status post right shoulder arthroscopy with distal clavicle resection and rotator cuff repair on 03/12/14. Patient's diagnosis on 03/28/14 included right shoulder sprain/strain, right shoulder tendinitis, right shoulder rotator cuff syndrome, and right elbow sprain/strain. Physical examination on 03/18/14 and 04/15/14 revealed well-healed incisions with no infection, sutures removed and steri strips applied. Slight edema noted over the postoperative right shoulder. Medications include Anaprox and Ultracet. Per treating physician's report dated 04/15/14, patient's pain is rated 7-8/10 and she is attending physical therapy two times a week. The X-Force Stimulator is a proprietary device that utilizes a unique electrical signal to deliver monophasic, peaked impulses directly to the joint. The device is a dual modality unit, offering TEJS and TENS functions that both use electrical stimulation to combat pain found in the joint capsule. The X-Force Stimulator is a non-invasive, non-addictive form of therapy used to help relieve the symptoms caused by arthritis and other joint conditions. The MTUS guidelines are silent on X-Force stimulators. However, they discuss the Criteria for Use of TENS Unit on page 116 and state that "There is evidence that other appropriate pain modalities have been tried (including medication) and failed." Also, the recommended trial period is for only 30 days. Per Request for Authorization form addendum dated 03/18/14, treating physician states that the X-Force unit "is being prescribed as an adjunct to conservative treatment as part of the customized functional restoration program that is specifically designed for this patient." In this case, the patient is currently attending physical therapy sessions, per treating physician report dated 04/15/14. Treating physician has not documented that other treatment modalities have been tried and failed. Furthermore, prior to purchase, MTUS requires documentation of 1 month trial with successful outcome. The request does not meet guideline indications; therefore, it is not medically necessary.

Retrospective (DOS: 03/18/2014) Solar care FIR heating system and FIR heating pad purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Infrared therapy (IR)

Decision rationale: The patient presents with postsurgical right shoulder pain rated 9/10 with radiation to the right upper extremity and associated numbness, tingling, burning sensation and swelling. The request is for Retrospective (DOS: 03/18/2014) Solar care FIR heating system and FIR heating pad purchase. The patient is status post right shoulder arthroscopy with distal clavicle resection and rotator cuff repair on 03/12/14. Patient's diagnosis on 03/28/14 included right shoulder sprain/strain, right shoulder tendinitis, right shoulder rotator cuff syndrome, and right elbow sprain/strain. Physical examination on 03/18/14 and 04/15/14 revealed well-healed incisions with no infection, sutures removed and steri strips applied. Slight edema noted over the postoperative right shoulder. Medications include Anaprox and Ultracet. Per treating physician report dated 04/15/14, patient's pain is rated 7-8/10 and she is attending physical therapy two times a week. MTUS is silent with regards to Infrared therapy (IR), however ODG-TWC Low Back Chapter states: "Infrared therapy (IR) Not recommended over other therapies." Per Request for Authorization form addendum dated 03/18/14, treating physician states "FIR Heat Pad, portable, use daily as needed. Recommended 6-8 hours per day. Patient would benefit from a purchase of this item." ODG does not recommend Infrared therapy over other therapies. Therefore, the request is not medically necessary.