

Case Number:	CM15-0004105		
Date Assigned:	01/15/2015	Date of Injury:	10/22/2008
Decision Date:	03/24/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/08/2015

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, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 worker is a 68-year-old female who reported an injury on 10/22/2008 due to an unspecified mechanism of injury. On 01/07/2015, she presented for a followup evaluation. She reported cervical spine discomfort rated at a 6/10 and upper extremity pain rated at a 7/10. It was noted that she continued to use her TENS unit and found this helpful in mitigating her pain. She also had reports of right wrist, hand, and forearm pain, right elbow pain, right shoulder pain, right sided neck pain, constipation, depression, and left hand pain. A physical examination showed mild visible atrophy in the thenar area of the right wrist and hand and slight to moderate tenderness to palpation of the thumb and thenar area over the CMC joint and dorsum of the right wrist. Carpal compression test was positive on the right with tingling in all fingers. An examination of the left shoulder showed positive impairment test and range of motion with flexion of 130 degrees and abduction of 110 degrees as well as tenderness over the acromioclavicular region. The cervical spine showed slight tenderness and spasm of the paracervical muscles with range of motion at 90% with flexion, 70% with extension and right and left lateral flexion. Spurling's sign was positive to the right, producing right shoulder pain and scapular pain and was negative to the left. Her sensation was noted to be moderately decreased over the right thumb and thenar area and adjoining area of the index finger as well. She was diagnosed with status post right wrist fracture, right shoulder pain with impairment, right cervical strain with radicular symptoms, and secondary depression due to chronic pain. The treatment plan was for purchase of a lift chair for scooter and OrthoStim unit supplies. The rationale for the request was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ortho stim unit supplies: 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
Page(s): 114-116.

Decision rationale: The California MTUS Guidelines indicate that while using an ortho unit, documentation should be provided regarding how often the unit was used and the duration of sessions as well as an objective improvement in function. Based on the clinical documentation submitted for review, the injured worker was noted to have been using a TENS unit for treatment. However, there was a lack of documentation indicating that she needs replacement supplies or that the unit was not working properly. Also, no information was provided regarding a quantitative decrease in pain and objective improvement in function or how often the unit was used and for how long. Therefore, the request would not be supported. As such, the request is not medically necessary.

Purchase lift chair for scooter: 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 Knee and Leg, DME

Decision rationale: According to the Official Disability Guidelines, durable medical equipment is defined as equipment that can withstand repeated use, can normally be rented and used by successive patients, and appropriate for use in the home. Based on the clinical documentation submitted for review, the injured worker was noted to be symptomatic regarding multiple body regions. However, there was a lack of documentation stating a clear rationale for the medical necessity of a lift chair for a scooter. Without a clear rationale indicating medical necessity of this request, the request would not be supported. In addition, a purchase of DME would not be supported as the guidelines recommend rental of durable medical equipment. As such, the request is not medically necessary.