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| Case Number: | CM15-0144959 | | |
| Date Assigned: | 07/30/2015 | Date of Injury: | 02/20/2002 |
| Decision Date: | 08/31/2015 | UR Denial Date: | 07/15/2015 |
| Priority: | Standard | Application Received: | 07/27/2015 |

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: North Carolina
Certification(s)/Specialty: Family Practice

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 60-year-old female patient who sustained an industrial injury on February 20, 2002. A recent impairment rating report dated January 29, 2015 reported the following treating diagnoses: arthroplasty, shoulder; rotator cuff syndrome; tear medial meniscus, knee; lumbar disc disease with myelopathy; adhesive capsulitis, shoulder; persistent insomnia; reactionary stress, and prolonged depression. The patient has reached maximum medical improvement. There was subjective complaint of moderate neck pain; severe left shoulder, wrist, hip and knee pains. The patient is using Tylenol # 4, Prilosec, Topical cream, and Xanax. The patient may return to a modified work duty. A request noted made on June 11, 2015 for durable medical equipment an X-Force stimulator unit and supplies along with a Solar care heating system treating the bilateral shoulders and left knee. A recent primary treating office visit dated June 11, 2015 reported subjective complaint of having severe left shoulder, neck, lower back, right shoulder, left wrist and knee pains. Medications noted unchanged. The patient is to remain permanent and stationary.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-force with solar care for home left shoulder and left knee (purchase): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation (NMES device) Transcutaneous Electrotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) durable medical equipment.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested item. Per the Official Disability Guidelines section on durable medical equipment, DME is primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury. DME equipment is defined as equipment that can withstand repeated use i.e. can be rented and used by successive patients, primarily serves a medical function and is appropriate for use in a patient's home. The requested DME does not serve a purpose that cannot be accomplished without it. The prescribed equipment does not meet the standards of DME per the ODG. Therefore, the request is not certified.

Follow-up as needed: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee/Leg, Office Visits.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) medical reevaluation.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The ODG, states follow up medical visits are based on medical necessity and the patient's progress, symptoms and ongoing complaints. In this case, the need for follow up is established but the request is for indefinite amount of follow up visits. This cannot be approved as the need for further follow up visits will be dictated by the patient's condition and progress and medical necessity which cannot be determined indefinitely.