

Case Number:	CM15-0182906		
Date Assigned:	09/23/2015	Date of Injury:	03/04/2013
Decision Date:	11/06/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	09/17/2015

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

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 58-year-old female who sustained an industrial injury on March 4, 2013. Diagnoses related to this request have included right shoulder contusion and right rotator cuff tear. An MRI performed 5-12-2015 of the right shoulder showed "high-grade, partial-to-full-thickness tear of right rotator cuff," and, on 8-26-2015, a request for right rotator cuff repair and subacromial decompression surgery was approved. As of this request the surgery had not been completed, but documented treatment included 3 sessions of physical therapy stated in the 3-10-2015 note to have made her condition worse, Toradol injection, ice, heat, TENS unit, home exercise and medication. The injured worker continued to report neck and bilateral shoulder pain noted on 8-19-2015 as rated 7 out of 10, and she reported difficulties with dressing and personal care. She had been working part time with restrictions, but was noted to be out of work pending surgery. The treating physician's plan of care includes two weeks of home health care, a bed lounger, and thermotech neck and shoulder infrared heating pad, but this was denied on 9-9-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health care (weeks) Qty: 2.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

Decision rationale: The current request is for Home health care (weeks) Qty: 2.00. The RFA is dated 08/31/15. Treatment history include physical therapy, Toradol injection, ice, heat, TENS unit, home exercise and medications. The patient is not working. MTUS Guidelines, Home Service Section, page 51, states, "Recommended only for otherwise recommended medical treatments for patients who are home bound on a part-time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed". Per report 08/12/15, the patient presents with continued right shoulder pain, despite conservative measures. Examination revealed positive tenderness, decreased range of motion, weakness and positive impingement sign. The treater recommended a right shoulder arthroscopy rotator cuff repair. On 08/31/15, request was made for home health care 4 hours a day for 5 days/2 weeks following surgery, bed lounger, and a thermotech neck and shoulder infrared heating pad. The medical records indicate that the patient underwent a right rotator cuff repair and subacromial decompression on 09/07/15. MTUS guidelines are clear that home health care is for medical treatment only and does not include homemaker services or personal care when this is the only care needed. In this case, there is no documentation that this patient requires medical treatment from home. Therefore, the request is not medically necessary.

Bed lounger (indefinite use) Qty: 1.00: 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) Knee and Leg Chapter, under Durable Medical Equipment (DME) and Other Medical Treatment Guidelines aetna.com/cpb/medical/data/400_499/0456.html.

Decision rationale: The current request is for Bed lounger (indefinite use) Qty: 1.00. The RFA is dated 08/31/15. Treatment history include physical therapy, Toradol injection, ice, heat, TENS unit, home exercise and medications. The patient is not working. The ACOEM, MTUS and ODG guidelines do not specifically discuss bed loungers. Bed lounger is a chair shaped cushion. Aetna guidelines at aetna.com/cpb/medical/data/400_499/0456.html state: Aetna does not cover most therapeutic pillows and cushions because they do not meet Aetna's contractual definition of durable medical equipment (DME) in that they are not durable and because they are not primarily medical in nature and not mainly used in the treatment of disease or injury. Official Disability Guidelines, Knee and Leg Chapter, under Durable Medical Equipment (DME) has the following: Recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME) below. Most bathroom and toilet supplies do not customarily serve a medical purpose and are primarily used

for convenience in the home. Medical conditions that result in physical limitations for patients may require patient education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. The term DME is defined as equipment which: (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients; (2) Is primarily and customarily used to serve a medical purpose; (3) Generally is not useful to a person in the absence of illness or injury; & (4) Is appropriate for use in a patient's home. Per report 08/12/15, the patient presents with continued right shoulder pain, despite conservative measures. Examination revealed positive tenderness, decreased range of motion, weakness and positive impingement sign. The treater recommended a right shoulder arthroscopy rotator cuff repair. On 08/31/15, request was made for home health care 4 hours a day for 5 days/2 weeks following surgery, bed lounger, and a thermotech neck and shoulder infrared heating pad. The medical records indicate that the patient underwent a right rotator cuff repair and subacromial decompression on 09/07/15. While ODG does not address bed loungers or cushions, it does set forth several criteria regarding durable medical equipment. In this case, the primarily and customarily use of a cushion is not to serve a medical purpose, and it would likely remain useful even in the absence of illness or injury. While the provider feels as though this is an appropriate medical intervention for this patient, a cushion or pillow does not satisfy ODG criteria for durable medical equipment and therefore cannot be supported. The request is not medically necessary.

Thermotech neck and shoulder infrared heating pad (indefinite use) Qty: 1.00:
Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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 under infrared therapy.

Decision rationale: The current request is for Thermotech neck and shoulder infrared heating pad (indefinite use) Qty: 1.00. The RFA is dated 08/31/15. Treatment history include physical therapy, Toradol injection, ice, heat, TENS unit, home exercise and medications. The patient is not working. The MTUS and ACOEM Guidelines do not address this request. ODG Guidelines, Low Back chapter under infrared therapy states, "Not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute lower back pain, but only if used as an adjunct to a program of evidence-based conservative care-exercise". Per report 08/12/15, the patient presents with continued right shoulder pain, despite conservative measures. Examination revealed positive tenderness, decreased range of motion, weakness and positive impingement sign. The treater recommended a right shoulder arthroscopy rotator cuff repair. On 08/31/15, request was made for home health care 4 hours a day for 5 days/2 weeks following surgery, bed lounger, and a thermotech neck and shoulder infrared heating pad. The medical records indicate that the patient underwent a right rotator cuff repair and subacromial decompression on 09/07/15. In this case, ODG states a limited trial may be considered for treatment of "acute LBP," and the current request is specific to the neck and shoulder. In addition, this heat modality is not recommended over other heat therapies. Therefore, this request is not medically necessary.