

Case Number:	CM15-0201016		
Date Assigned:	10/16/2015	Date of Injury:	07/01/2010
Decision Date:	11/24/2015	UR Denial Date:	10/12/2015
Priority:	Standard	Application Received:	10/13/2015

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: Massachusetts

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

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 69-year-old female, who sustained an industrial injury on 7-1-2010. Several documents within the submitted medical records are difficult to decipher. The injured worker is undergoing treatment for left hip degenerative arthritis, left hip greater trochanteric bursitis, left shoulder strain-sprain and left shoulder partial thickness rotator cuff tear. Medical records dated 10-1-2015 indicate the injured worker complains of left shoulder and hip pain. She rates the shoulder pain 7 out of 10 and the hip pain 9 out of 10. She reports the pain has been constant since the last visit. The treating physician indicates modified work with restrictions. Exam dated 5-21-2015 indicates shoulder pain 5-6 out of 10 and hip pain 2 out of 10. Physical exam dated 10-1-2015 notes tenderness to palpation of left hip with decreased range of motion (ROM). Treatment to date has included injections, medication and activity alteration. The original utilization review dated 10-12-2015 indicates the request for high adjustable chair is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

High Adjustable Chair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder (Acute & Chronic); Carpal Tunnel Syndrome (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Durable medical equipment (DME).

Decision rationale: The claimant sustained a cumulative trauma work injury with date of injury in July 2010. She is being treated for left shoulder, right knee, and left hip pain. When seen, she was having persistent left hip and left shoulder pain. Hip pain was rated at 9/10. Physical examination findings included left groin tenderness and tenderness to a lesser extent over the greater trochanteric. She had age limited range of motion which was painful. Hip range of motion includes flexion of 100 degrees and extension of 5 degrees. Authorization is being requested for an adjustable chair. Durable medical equipment can be recommended if there is a medical need and if the device or system meets the Medicare definition of durable medical equipment (DME) and may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. In this case, the claimant has functional hip range of motion with flexion of 100 degrees. A high adjustable chair is not medically necessary.