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| <b>Case Number:</b>   | CM15-0028598 |                              |            |
| <b>Date Assigned:</b> | 02/20/2015   | <b>Date of Injury:</b>       | 04/16/1999 |
| <b>Decision Date:</b> | 04/06/2015   | <b>UR Denial Date:</b>       | 01/22/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 02/17/2015 |

### 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: New York, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency Medicine

### 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 59 year old female, who sustained an industrial injury on 4/16/1999. The diagnoses have included bilateral thoracic outlet syndrome, bilateral adhesive shoulder capsulitis, lumbar intervertebral disc disease and upper extremity overuse syndrome. Treatment to date has included IF (inferential stimulator) unit, medications, Botox injection, modified activity, psychological treatment home cleaning service and right trochanteric bursa steroid injections. Currently, the IW complains of increasing depression, anxiety, agoraphobia and unstable gait. She reports increasing symptoms of left posttraumatic brachial plexopathy with increasing weakness and swelling in the left upper extremity and pain. Objective findings included that she is anxious with an unstable gait. She has severe right trochanteric bursa tenderness. She has moderate left scalene and pectoralis minor tenderness with brachial plexus Tinel and positive left Roos, and distal intrinsic hand weakness in the left hand with swelling of the digits. There is hypoesthesia in the left C8-T1 dermatome to pinwheel testing. On 1/22/2015, Utilization Review non-certified a request for replacement of home IF (inferential stimulator) unit and service dog noting that the clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The ACOEM Guidelines were cited. On 1/22/2015, the injured worker submitted an application for IMR for review of replacement of home IF unit and service dog.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DME- Replacement of Home IF Unit and Service Dog: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**Decision rationale:** Guidelines do not support the use of interferential therapy for pain relief associated with soft tissue injury, low back pain or for enhancing wound/fracture healing. In this case, the patient suffered from various soft tissue injuries including bursitis. There is no evidence in the literature which indicates efficacy of interferential therapy to treat such maladies. Thus, the request for interferential stimulator is not medically necessary and appropriate. Similarly, there is no documented functional impairment that guidelines would support and recommend the need for a service dog. Thus the request for a service dog is not medically necessary and appropriate.

**6 Molly Maid Home Service 4 hours per week (duration and date unspecified): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

**Decision rationale:** In this case, the patient has ongoing complaints of weakness and unstable gait but clinical documentation does not indicate any specific functional limitations. Documents do indicate that the patient is functional enough to care for a dog. Since there is no evidence of poor functional capability in the patient, per guidelines, the request for Molly Maid service is not medically appropriate and necessary.

**Additional Psychological Treatment 18 visits: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 101-102.

**Decision rationale:** Guidelines recommend psychological therapy for appropriately identified patients during treatment of chronic pain. Clinical documentation indicates a diagnosis of major depressive disorder. However, there is no mental status examination noted in the records. In this case, the lack of basic mental status data negates the medical necessity for additional psychological treatments for anxiety. Thus the request for psychological treatments is not medically necessary and appropriate.

