

Case Number:	CM15-0057296		
Date Assigned:	04/28/2015	Date of Injury:	04/04/2011
Decision Date:	05/22/2015	UR Denial Date:	03/09/2015
Priority:	Standard	Application Received:	03/25/2015

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 60-year-old female, who sustained an industrial injury on April 4, 2011. The injured worker has been treated for left shoulder and left knee complaints. The diagnoses have included right shoulder strain, rotator cuff syndrome of the shoulder, calcifying tendinitis of the shoulder, left knee degenerative disease and left knee medial meniscus tear. Treatment to date has included medications, radiological studies, injections, shock-wave therapy and left knee surgery. Current documentation dated February 26, 2015 notes that the injured worker reported constant, sharp right shoulder pain with locking of the shoulder. Examination of the left shoulder revealed tenderness to palpation over the entire shoulder, a decreased range of motion and positive special orthopedic testing. The treating physician's plan of care included a request for a resistance chair and a freedom flex.

IMR ISSUES, DECISIONS AND RATIONALES

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

Resistance Chair: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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 equipment is used in assistance with exercise therapy. There is no clinical documentation provided which shows the need for this specialized equipment over regular home therapy or physical therapy. Therefore, the request is not certified.

Freedom Flex: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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 equipment is used in assistance with exercise therapy. There is no clinical documentation provided which shows the need for this specialized equipment over regular home therapy or physical therapy. Therefore, the request is not certified.