

Case Number:	CM13-0031215		
Date Assigned:	12/04/2013	Date of Injury:	10/18/2009
Decision Date:	06/17/2014	UR Denial Date:	09/18/2013
Priority:	Standard	Application Received:	10/02/2013

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. The expert reviewer is Board Certified in Family Medicine, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 38 year-old male who was injured at work on 10/18/09. The injury was primarily to his right shoulder. There is evidence for ongoing care since the time of the injury to the shoulder and wrist. The patient underwent surgical repair on 5/21/13 with arthroscopy, debridement, and biceps tenotomy with decompression. The Secondary Treating Physician's Progress Reports are included and corroborate ongoing symptoms of right shoulder and wrist pain. Diagnoses include the following right thumb pain, right wrist sprain/strain, right wrist weakness, right dorsal ganglion cyst, right shoulder pain, and dysfunction with impingement.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR SEGMENTAL PNEUMATIC APPL PNEUMATIC COMP SEG WITH CALIBR FOR THE RIGHT SHOULDER AND WRIST: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203-209, Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Postsurgical Treatment Guidelines.

Decision rationale: The MTUS/ACOEM Guidelines, the MTUS Chronic Pain Medical Treatment Guidelines, and the Post-Surgical Treatment Guidelines are all silent on the use of this type of device for the treatment of chronic shoulder and wrist pain. As such, the Official Disability Guidelines (ODG) were used instead. The ODG provides criteria for post-operative durable medical equipment. These guidelines state that post-operative cold therapy is recommended as an option after surgery, but not for nonsurgical treatment. There is no statement that any kind of compressive device for the shoulder or the wrist has been evaluated for efficacy. There is no medical justification in the records by the treating physician as to the rationale for the use of this type of device for this patient's chronic shoulder and wrist problem. As such, the request is not medically necessary.