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| Case Number: | CM14-0122470 | | |
| Date Assigned: | 08/08/2014 | Date of Injury: | 01/06/2006 |
| Decision Date: | 10/15/2014 | UR Denial Date: | 07/01/2014 |
| Priority: | Standard | Application Received: | 08/04/2014 |

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 51-year-old female who has submitted a claim for cervical strain, left frozen shoulder, left arm radiculopathy, left carpal tunnel syndrome and depression associated with an industrial injury date of January 6, 2006. Medical records from 2014 were reviewed, which showed that the patient complained of ongoing left shoulder and left wrist pain. Examination of the shoulder revealed flexion of 85 degrees, abduction of 75 degrees, numbness throughout the left upper extremity, grip of 60 in the right and 20 on the left and good effort on Jamar testing. Treatment to date has included left shoulder surgery with frozen shoulder, physical therapy and medications. Utilization review from July 1, 2014 denied the request for Retrospective request: Interferential Unit Purchase DOS 10/25/13, Retrospective request: Electrodes (18 pairs) DOS 10/25/13, Retrospective request: Ultrasling purchase DOS 10/25/13, Retrospective request: Shoulder Exercise Kit purchase DOS 10/25/13 and Retrospective request: Motorized Cold Therapy Unit Purchase DOS 10/25/13. The requests for the interferential unit and electrodes were denied because it was not documented 1) if the pain is ineffectively controlled due to diminished effectiveness of medications, 2) if there are side effects or a history of substance abuse, 3) if significant pain from postoperative conditions limit the ability to perform exercise programs/physical therapy treatment, or 4) if the patient was unresponsive to conservative measures. The request for the motorized cold therapy unit was denied because there is no provided rationale for its use. The request for ultrasling was denied because the patient underwent arthroscopic surgery and not open repair. The request for shoulder exercise kit was denied because there was no documentation of a rationale identifying the medical necessity of it rather than active participation in an independent home exercise program or post-operative PT.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request: Interferential Unit Purchase DOS 10/25/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Interferential Current Stimulation (.).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: Page 118-120 of CA MTUS Chronic Pain Medical Treatment Guidelines state that a one-month trial of the IF unit may be appropriate when pain is ineffectively controlled due to diminished effectiveness of medications, when pain is ineffectively controlled with medications due to side effects, in patients with a history of substance abuse, in the presence of significant pain from postoperative conditions limiting the ability to perform exercise programs/physical therapy treatment, or if the condition is unresponsive to conservative measures. In this case, there is no documentation regarding failure of pain medications or inability to perform physical therapy. There was no documented history of substance abuse, a postoperative status and unresponsiveness to conservative measures. There is also no documentation of a prior one-month trial of use of interferential unit to support further treatment (as implied by the purchase vs rental). The submitted medical records are insufficient. Furthermore, the records provided do not include the period covered by DOS. Therefore, the request for Retrospective request: Interferential Unit Purchase DOS 10/25/13 was not medically necessary.

Retrospective request: Electrodes (18 pairs) DOS 10/25/13: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The related request for Retrospective request: Interferential Unit Purchase DOS 10/25/13 has been deemed not medically necessary; therefore, all of the associated services, such as this request for Retrospective request: Electrodes (18 pairs) DOS 10/25/13 is likewise not medically necessary.

Retrospective request: Motorized Cold Therapy Unit Purchase DOS 10/25/13: 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 Official Disability Guidelines (ODG) Shoulder Chapter, continuous flow cryotherapy

Decision rationale: CA MTUS does not specifically address continuous-flow cryotherapy; however, the Official Disability Guidelines recommend continuous-flow cryotherapy as an option after surgery, but not for non-surgical treatment. Postoperative use generally may be up to 7 days, including home use. In this case, the patient complained of shoulder and left wrist pain. Shoulder arthroscopy was done in 2013 but the actual date was not specified on the records. In fact, the medical records submitted for review were from 2014. Medical necessity for the request cannot be established due to insufficient information. The clinical and functional status of the patient during the DOS is unknown. Therefore, the request for Retrospective request: Motorized Cold Therapy Unit Purchase DOS 10/25/13 is not medically necessary.

Retrospective request: Ultrasling purchase DOS 10/25/13: 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 Official Disability Guidelines (ODG) Shoulder Chapter, Sling

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines, Shoulder Chapter, was used instead. The ODG recommends sling/abduction pillow as an option following open repair of large and massive rotator cuff tears. In this case, patient did not have open repair of large and massive rotator cuff tears. There is no compelling rationale that would warrant the need for postoperative sling. Guidelines are not met for the purchase of Ultra Sling. Furthermore, the records provided do not include the period covered by the DOS. Therefore, the request for Retrospective request: Ultrasling purchase DOS 10/25/13 is not medically necessary.

Retrospective request: Shoulder Exercise Kit purchase DOS 10/25/13: 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) Shoulder Chapter, Home exercise kits

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines was used instead. ODG Shoulder Chapter recommends home exercise kits where home exercise programs and active self-directed home physical therapy are recommended. It also states that durable medical equipment should be primarily and customarily used to serve a medical purpose. In this case, the patient complained of left shoulder and left wrist pain. A shoulder exercise kit was purchased on 10/25/13.

However, the medical records submitted for review were from 2014, which do not mention any home exercise program. Medical necessity for the request cannot be established due to insufficient information. The clinical and functional status of the patient on the DOS is unknown. Therefore, the request for Retrospective request: Shoulder Exercise Kit purchase DOS 10/25/13 is not medically necessary.