

Case Number:	CM14-0166327		
Date Assigned:	10/13/2014	Date of Injury:	08/21/2012
Decision Date:	11/13/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/09/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain 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 injured worker is a 41-year-old male who sustained an injury on 8/21/12. As per 10/15/14 report, he presented with constant moderate 4-6/10 right shoulder pain. Objective findings revealed right shoulder flexion of 85/170, extension 20/30, abduction 80/170, adduction 45/80, internal rotation 30/60 and external rotation 35/80, +3 tenderness and spasm on the right upper trapezius, supraspinatus, deltoid and pec major, decreased right upper motor strength and sensation, positive supraspinatus press test and frozen shoulder test. MRI of the right shoulder dated 06/16/14 revealed acromioplasty with persistent subacromial and subdeltoid bursal scar tissue and it was a limited study due to extensive postsurgical ferromagnetic susceptibility artifact obscuring the distal rotator cuff insertion, much of the subacromial space as well as of the greater tuberosity. Past surgeries include left knee arthroscopic surgery and right shoulder surgery. He is currently on Medrox pain relief ointment, Hydrocodone, Naproxen Sodium, and Omeprazole. Previous treatments have included physical therapy, injections, acupuncture and medications. ■■■■■ splint was certified on 6/13/14 for the right shoulder and no other reference of its use or benefits was made. Diagnoses include adhesive capsulitis of right shoulder with postsurgical changes, internal derangement of left knee, diabetes mellitus, and anxiety disorder. The request for 3 month rental of ■■■■■ splint for right shoulder was denied on 10/01/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

3 month rental of ■■■■■ splint for right shoulder: 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), Shoulder (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 chapter

Decision rationale: The California MTUS/ACOEM does not address the issue. Per Official Disability Guidelines, [REDACTED] splint is recommended for the knee, elbow, wrist or finger are recommended as an adjunct to physical therapy with documented signs of significant motion stiffness/loss in the sub-acute injury or post-operative period (i.e., at least 3 weeks after injury or surgery), or in the acute post-operative period with a prior documented history of motion stiffness/loss in a joint along with additional surgery done to improve motion to that joint. A mechanical device for joint stiffness or contracture may be considered appropriate for up to 8 weeks when used for one of the following conditions: Joint stiffness caused by immobilization; Established contractures when passive range of motion is restricted; healing soft tissue that can benefit from constant low-intensity tension. Appropriate candidates include patients with connective tissue changes (e.g. tendons, ligaments) as a result of traumatic and non-traumatic conditions or immobilization, causing limited joint range of motion, including total knee replacement, ACL reconstruction, fractures & adhesive capsulitis; Used as an adjunct to physical therapy within 3 weeks of manipulation or surgery performed to improve range of motion. In this case, the IW has developed joint stiffness with adhesive capsulitis of the right shoulder which is not an indication for this device. There is no documentation of plan for adjunct physical therapy. The shoulder surgery was performed a few months ago. Furthermore, the request is for 3 month rental, which exceeds the guidelines recommendation of using this device for up to 8 weeks. As such, the criteria are not met and the request is considered not medically necessary.