

Case Number:	CM14-0107490		
Date Assigned:	08/01/2014	Date of Injury:	08/06/2013
Decision Date:	04/22/2015	UR Denial Date:	07/10/2014
Priority:	Standard	Application Received:	07/10/2014

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. 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
 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 58-year-old male who sustained an industrial injury on 8/6/13. The documentation dated 6/24/14 noted that injured worker has complaints of moderate right shoulder pain and neck pain. The diagnoses have included pain in joint involving shoulder region and other affections of shoulder region, not elsewhere classified. Treatment has included right shoulder surgery on 6/14/14, medications and physical therapy treatments. Work status continued temporary total disabled. On July 10, 2014, Utilization Review non-certified a request for X-Force stimulator unit, supplies including batteries, conductive garment and solar-care heating system purchase. CA MTUS chronic pain and ACOEM guidelines were cited in support of this decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

X Force stimulator unit QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): s 173-174, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post operative pain (transcutaneous electrical nerve stimulation) Page(s): s 116-117, Postsurgical Treatment Guidelines Page(s): 11.

Decision rationale: The IW had right shoulder surgery on 6/14/14. The details of the surgery were not available for review. It is not clear from the record who was the operating surgeon. The CA MTUS post-surgical treatment guidelines; "Only the surgeon who performed the operation, a nurse practitioner, or physician assistance working with the surgeon, or a physician designated by that surgeon can make a determination of medical necessity and prescribe post-surgical treatment under this guideline." According to chronic pain guidelines, TENS units are recommended in the first 30 days post-surgery. This treatment has not been shown to be effective for pain from orthopedic procedures other than thoracotomy pain. It is not clear from the records if the requesting provider is the surgeon or the surgeon's designee. Additionally, the request exceeds the 30 day recommend post-operative period. As such, the request for X-Force stimulator unit is not medically necessary.

Supplies QTY 1: 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 TENS, post operative pain (transcutaneous electrical nerve stimulation) Page(s): s 116-117.

Decision rationale: The request for a X-Force stimulator unit is not medically necessary, therefore supplies are not necessary

Supplies/ batteries QTY 1: 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 TENS, post operative pain (transcutaneous electrical nerve stimulation) Page(s): s 116-117.

Decision rationale: The request for a X-Force stimulator unit is not medically necessary, therefore supplies are not necessary

Conductive garment QTY: 2: 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 TENS, post operative pain (transcutaneous electrical nerve stimulation) Page(s): s 116-117.

Decision rationale: The request for a X-Force stimulator unit is not medically necessary, therefore supplies are not necessary

Solar-Care heating system purchase QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, heat/ cold applications.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back.

Decision rationale: The IW had right shoulder and neck pain and had undergone shoulder surgery on 6/14/14. It is unclear from the records where the intended application of the Solar-Care heating system, neck or shoulder. According to ODG guidelines, heat/cold applications are recommended, although there is insufficient testing to determine if there is effectiveness in treating mechanical neck disorders. It is unclear from the records if the IW has a mechanical neck disorder. It is also unclear if the intent is for treatment of the neck. Without these details, the request is not medically necessary.