

Case Number:	CM15-0120341		
Date Assigned:	06/30/2015	Date of Injury:	11/11/2014
Decision Date:	07/30/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	06/22/2015

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 a 52 year old female who sustained an industrial injury on 11/11/14 from a slip and fall injuring her shoulder, wrist, knee, left groin. She was medically evaluated and received medications, physical therapy, and acupuncture. X-rays (11/14/14) of shoulder were negative for fractures. Right shoulder pain persisted and an MRI of the right shoulder showed rotator cuff tear. Diagnoses were right shoulder strain, right wrist strain, left groin strain. She currently complains of diminished mobility of the right shoulder; left hip pain persists; left knee pain. Activities of daily living are limited and needs to use the left upper extremity to perform activities. She has sleep difficulties. On physical exam the left hip had slightly restricted range of motion and tenderness in the left groin; there was low level left knee irritability and tenderness; right shoulder range of motion was mildly restricted and shoulder was markedly frozen, diffusely tender with rotator cuff weakness. Medications were not specifically identified. Diagnoses include full thickness rotator cuff tear; disorder of the rotator cuff; hip impingement syndrome; strain of left knee; strain of right wrist; cervical strain; cervical radiculitis. Treatments to date include physical therapy with minimal benefit; acupuncture more helpful; medications. Diagnostics include diagnostic ultrasound of the right shoulder showing partial rotator cuff tear; MRI of the right shoulder (1/8/15) showing small full-thickness tear, spurring, joint effusion, glenohumeral and acromioclavicular osteoarthritis; MRI of the lumbar spine (3/30/15) showing partial disc desiccation; MRI cervical spine (4/6/15) showing mild disc degeneration, foraminal stenosis; right wrist x-rays were unremarkable; electrodiagnostic study of the upper extremities

(4/6/15) which was abnormal and consistent with a cervical radiculopathy on the right side. On 5/19/15, Utilization Review evaluated the request for purchase of Theracane.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of Theracane: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

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 itself is used for massage. The provided clinical documentation for review does not show sufficient evidence for the purchase of this item, as all criteria for DME have not been met as outlined above. Therefore, the request is not certified.