

Case Number:	CM15-0075965		
Date Assigned:	04/27/2015	Date of Injury:	12/16/2013
Decision Date:	06/01/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	04/21/2015

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: California, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 62 year old female, who sustained an industrial injury on December 16, 2013. The injured worker was diagnosed as having cervical, shoulder, elbow, carpal and hand sprain/strain, anxiety, depression, wrist tenosynovitis, elbow epicondylitis and shoulder rotator cuff syndrome. Treatment and diagnostic studies to date have included magnetic resonance imaging (MRI), therapy and medication. A progress note dated March 5, 2015 the injured worker complains of neck pain. Right shoulder pain is rated 7/10 with medication and 9-10/10 without medication and elbow and wrist pain rated 6/10 with medication and 8/10 without medication. She also has pain in the right hand rated 6/10 with medication and 9-10/10 without medication. Physical exam notes the injured worker appears anxious and depressed. There is right shoulder tenderness with decreased range of motion (ROM) and positive impingement. The right elbow and wrist are tender with decreased range of motion (ROM) with positive Mill's and Cozen's tests. The plan includes magnetic resonance diagnostic studies, various therapy treatments, hot/cold unit and wrist/hand brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/Cold Unit purchase or rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder Continuous-flow Cryotherapy.

Decision rationale: The patient presents with pain affecting the right shoulder, elbow, wrist, hand, and fingers. The current request is for Hot/Cold unit purchase or rental. The treating physician states, "Request authorization for hot/cold unit." No further explanation was given for this request. The ODG guidelines state, "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." In this case, the patient is not in the post-surgical timeframe which could require usage of this medical device and the request is unclear if it is for a purchase or a rental. The current request is not medically necessary and the recommendation is for denial.

Chiropractic times 6 sessions cervical right shoulder, elbow, and wrist or hand or fingers:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

Decision rationale: The patient presents with pain affecting the right shoulder, elbow, wrist, hand, and fingers. The current request is for Chiropractic times 6 sessions cervical right shoulder, elbow, and wrist or hand or fingers. The treating physician states, "Request authorization for chiropractic treatment." No further explanation was given for this request. The MTUS guidelines state, "Recommended for chronic pain if caused by musculoskeletal conditions." The MTUS guidelines do not recommend chiropractic therapy for the shoulder. In this case, the treating physician has requested a treatment which is not supported by MTUS guidelines. The current request is not medically necessary and the recommendation is for denial.