

Case Number:	CM13-0008714		
Date Assigned:	12/18/2013	Date of Injury:	12/31/2008
Decision Date:	02/21/2014	UR Denial Date:	08/01/2013
Priority:	Standard	Application Received:	08/08/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Illinois, Texas, and West Virginia. 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 physician 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 45-year-old female who reported an injury on 12/31/2008. The mechanism of injury was a motor vehicle accident. She had initial complaints of head, face, and upper torso pain. Her initial conservative care included chiropractic treatment and 18 weeks of physical therapy. She continued to treat her symptoms with the use of acupuncture as well as topical and oral analgesics. In 2009, the patient had an MRI of the cervical spine that reported a congenitally narrow canal with small disc bulges at C4-5 and C5-6, as well as an osteophyte complex at C5-6 causing severe left neural foraminal narrowing. She also had an MRI of the lumbar spine performed in 2009 that revealed a small diffuse posterior disc bulge with annular tear at L4-5 that abuts the traversing L5 roots in the lateral recesses. The patient is also noted to have had a normal MRI of the brain in 2009. An EMG of the bilateral lower extremities performed on 05/29/2013 revealed normal findings as did an NCS on the same date. An EMG/NCV of the upper extremities performed on 06/06/2013 also had normal results. The patient participates in a home exercise program that includes tai chi and yoga. A repeat MRI of the cervical spine performed on 09/30/2013 showed only a slight worsening of the disc herniation at C3-4. A repeat MRI of the lumbar spine performed on 09/30/2013 showed no differences from the previous study. Despite continuing care, the patient has persistent complaints of cervical and lumbar pain as well as left shoulder and left rib cage pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase Interspec-IF Devise (quantity #1): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 118-121.

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS/ACOEM Guidelines do not recommend the use of interferential current or neuromuscular stimulation. However, despite the lack of evidence supporting interferential current therapy, guidelines have set forth criteria that must be met before this therapy can be used. These criteria include objectively documented evidence that the patient's pain is ineffectively controlled due to the diminished effectiveness of medication; pain is ineffectively controlled with medication due to side effects; history of substance abuse; significant pain from postoperative conditions limit the ability to perform a physical therapy program; and the patient has been unresponsive to conservative measures including repositioning, heat, and ice. If those criteria are met, then a 1 month home trial may be appropriate. Neuromuscular stimulation, however, is not recommended. This type of therapy is primarily used as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. As an Interspec-IF device combines both interferential current and neuromuscular electrical stimulations, the effectiveness of both the treatments must be assessed. Unfortunately, guidelines do not recommend neuromuscular electrical stimulation. Furthermore, there was no documented evidence provided within the medical records of the patient's failed trials of medications or conservative therapies, nor was there any discussion of an adjunctive physical therapy program to be initiated. As such, the request for purchase of an Interspec-IF device #1 is non-certified.

Monthly supplies for IF Devise (quantity #1): 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Hot/cold continuous therapy unit (quantity #1): 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, Continuous Flow Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Continuous Flow Cryotherapy.

Decision rationale: The California MTUS/ACOEM Guidelines do not specifically address the use of continuous flow hot or cold treatment; therefore, the Official Disability Guidelines were supplemented. ODG recommends continuous flow therapy as an option after surgery, but not for nonsurgical treatment. As guidelines do not recommend, the need for continuous flow therapy is not indicated at this time. As such, the request for hot/cold continuous therapy unit #1 is non-certified.

Hot/cold pads (quantity #1): 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Assembly straps 16\''/48\'': 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.