

Case Number:	CM13-0023895		
Date Assigned:	11/15/2013	Date of Injury:	01/18/2013
Decision Date:	05/29/2014	UR Denial Date:	09/09/2013
Priority:	Standard	Application Received:	09/12/2013

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 Internal 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 in question was injured on 1/18/13 and seen initially by her physician who later transferred her care to another physician with more expertise in treating her symptomatology. He first saw her on 7/15/13. He subsequently saw her on 8/19/13 and noted that she had pain on palpation and decreased range of motion of her cervical spine and that she had dull pain of her right shoulder that radiated to her arm and that she also had frequent sharp lumbar pain that radiated to her bilateral hips. There was also noted to be dull pain of her right hip and thigh. A summary of the diagnostic tests showed that she had disc bulges on cervical MRI and right shoulder supraspinatus tear and tendinitis and infraspinatus tendinitis. Also, MRI of her lumbar spine showed disc bulge and grade 1 anterolisthesis of L5-S1. The MRI of the right and left hips were noted to be normal. EMG showed mild C5-C6 radiculopathy and mild bilateral carpal tunnel syndrome. Also, L5-S1 radiculopathy was demonstrated. His diagnoses were neck pain, lumbar pain, right upper extremity pain and right pelvis and thigh pain. He requested physical therapy, acupuncture and physical therapy with functional restoration program. Also Vital Wrap with hot and cold applications and an interferential electric muscle stimulator was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

INTERFERENTIAL ELECTRIC MUSCLE STIMULATOR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 119-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Electric Muscle Stimulator Page(s): 118-120.

Decision rationale: The above treatment is controversial and the studies cited are of questionable reliability. Inferential electric muscle stimulator is a technique that seeks to utilize electrotherapy applied to tissue in order to provide alleviation of symptoms. There have been randomized trials utilizing this technique in order to treat jaw, shoulder, neck, back, and knee pain. However, these trials have been either inconclusive or negative and the study trials have been poorly designed. There is insufficient evidence to recommend this modality in the treatment of soft tissue injury in general. There is also no standardized protocol for the application of this treatment. In conclusion, the section states that IFE is not recommended as an isolated intervention but may possibly be utilized if pain is not well controlled with medications and if conservative modalities such as heat and cold applications and physical therapy and such modalities as FRP have not proved effective. The patient was to be started on a functional restoration program and acupuncture. Without failure of these conservative modalities, the request is not medically necessary.

VITAL WRAP: COLD/HEAT FOR HOME USE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints Page(s): 300, 338.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints Page(s): 300, 338.

Decision rationale: Both the sections on the knee and low back of the ACOEM guidelines recommend the use of cold for the first couple days of injury and thereafter the use of either heat or cold or both at home. There is no mention of the use of PT for this modality or the use of a special apparatus such as the Vital Wrap to apply cold or heat. There is no study in the literature search proving that this system was more efficacious than the local application of heat and cold at home.