

Case Number:	CM13-0025997		
Date Assigned:	11/22/2013	Date of Injury:	06/18/2012
Decision Date:	02/28/2014	UR Denial Date:	08/23/2013
Priority:	Standard	Application Received:	09/18/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma and Texas. 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:

This patient is a 31 year old female who reported an injury on 06/18/2012. The patient is diagnosed with cervical disc bulge, radiculopathy, insomnia, anxiety, and right shoulder sprain/strain. The only physician progress report submitted is an orthopedic permanent and stationary report, dated 07/15/2013 by [REDACTED]. The patient reported 6-8/10 pain. Physical examination revealed stiffness and guarding of the cervical spine, tenderness to palpation, spasm, trigger points, and decreased range of motion. The patient was permanent and stationary at that time. Future medical treatment included oral anti-inflammatories, pain medication, injections, physical therapy, a cervical collar, and cervical traction.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of DME: Solar Care heating pad: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Infrared therapy (IR

Decision rationale: ACOEM Guidelines state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as heat/cold applications, but these palliative tools may be used on a trial basis; but should be monitored closely. Official Disability Guidelines state that infrared therapy is not recommended over other heat therapies. The patient has been shown to have pain in her cervical spine. However, there is no documentation stating the reason that deep heating is required for this patient over the application of traditional heat application. In the absence of this information clarifying the request, it is not supported by guidelines. Therefore, the request is non-certified.

X-Force stimulator unit: 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 Page(s): 117-121.

Decision rationale: California MTUS Guidelines state the criteria for the use of TENS includes documentation of pain of at least 3 months' duration and evidence that other appropriate pain modalities have been tried and failed. A one month trial period of the TENS unit should be documented, as an adjunct to ongoing treatment modalities within a functional restoration approach, with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. The documentation submitted for review failed to include evidence of a trial of a TENS unit prior to this request. Additionally, it is not stated whether the patient is participating in a home exercise program or physical therapy at this time. Furthermore, it is not documented as to the reason the patient requires the combination TENS and TEJS unit over a standard TENS unit. In the absence of this information, the request is not supported. Therefore, the request is non-certified.

Conductive garment two (2) and three (3) month supplies: 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 Page(s): 117-121.

Decision rationale: California MTUS Guidelines state the criteria for the use of TENS includes documentation of pain of at least 3 months' duration and evidence that other appropriate pain modalities have been tried and failed. Form-fitting TENS device is only considered medically necessary when there is documentation that there is such a large area that requires stimulation that a conventional system cannot accommodate the treatment. It is not documented as to the reason the patient requires the combination TENS and TENS unit over a standard TENS unit. In the absence of this information, the request is not supported. As the request for an X-Force Stimulator is not authorized, the request for conductive garment is also not medically necessary. Therefore, the request is non-certified.

