

Case Number:	CM13-0026127		
Date Assigned:	11/22/2013	Date of Injury:	05/04/2012
Decision Date:	02/24/2014	UR Denial Date:	09/13/2013
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 Certificate in Pediatric Rehabilitation Medicine, and is licensed to practice in Illinois, Indiana, 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:

The patient is a 52-year-old female who reported an injury on 05/04/2012. The mechanism of injury was stated to be a box falling on top of her hands, after which she began having bilateral hand pain. The patient indicated that activities of daily living are limited secondary to pain, and these include mopping and sweeping. The patient was noted to have a sensory examination that was intact to light touch, pinprick and 2 point discrimination in all dermatomes in the bilateral upper extremities. The motor strength was noted to be 5/5 in the bilateral upper extremities and the deep tendon reflexes were noted to be normal. The patient's diagnoses were noted to include left hand tendonitis secondary to crush injury and left wrist sprain/strain. The request was made for Acupuncture 1 x 4, Chiropractic 2 x 4, and an IF unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture, 1x4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: California MTUS guidelines recommend Acupuncture as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The time to produce functional improvement is 3 to 6 treatments, and Acupuncture treatments may be extended if functional improvement is documented, including either a clinically significant improvement in activities of daily living or a reduction in work restrictions. The clinical documentation submitted for review failed to indicate the patient was in a program of physical rehabilitation. Additionally, it failed to provide findings that would support the necessity for acupuncture. Given the above, the request for Acupuncture, 1 x 4, is not medically necessary or appropriate.

Chiropractic, 2x4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58. Decision based on Non-MTUS Citation ODG Forearm, Wrist, and Hand Chapter - Manipulation.

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

Decision rationale: California MTUS Guidelines indicate that manual therapy is not recommended for the wrist and hand. There is a lack of documentation indicating any exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for Chiropractic, 2 x 4, is not medically necessary.

IF (Interferential) Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on Interferential current stimulation Page(s): 118.

Decision rationale: California MTUS does not recommend interferential current stimulation (ICS) as an isolated intervention; rather, it states, ICS should be used in conjunction with recommended treatments including return to work, exercise and medication. The clinical documentation submitted for review failed to indicate the patient would be using the interferential unit combined with recommended treatments. Additionally, there was a lack of documentation indicating if the request was for purchase or for rental. Given the above and the lack of clarification, as well as the lack of objective physical findings to support the use of an interferential unit, the request for IF (interferential) unit is not medically necessary or appropriate.

Motorized Cold Therapy for the left hand/wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG and the Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 263-264.

Decision rationale: ACOEM Guidelines indicate that at-home, local applications of cold packs are warranted during the first few days of acute complaints; and, thereafter, applications of heat packs. There was a lack of documentation indicating the necessity for a motorized cold therapy unit for the left hand/wrist versus application of hot or cold packs. Given the above and the lack of documentation of exceptional factors necessitating non-adherence to guidelines, the request for motorized cold therapy for the left hand/wrist is not medically necessary.