MAXIMUS Federal Services

Case Number:	CM13-0038365		
Date Assigned:	12/18/2013	Date of Injury:	04/28/2005
Decision Date:	02/24/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	10/25/2013

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 Internal Medicine, has a subspecialty in Cardiology and is licensed to practice in 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 56-year-old female who reported an injury on 04/28/2005 due to a twisting motion injury to her bilateral knees. This resulted in both left and right knee arthroscopic surgeries. The patient also developed chronic hand, wrist, and back pain. The patient ultimately underwent extensor tendon repair in the hand and wrist. The patient's most recent clinical exam findings included persistent pain and stiffness of the right shoulder, right wrist, lumbar spine, and bilateral knees. Objective findings included tenderness and decreased range of motion in both knees, tenderness of the lumbar spine, tenderness of the right shoulder, and tenderness of the right wrist. The patient's diagnoses included status post extensor tendon repair of the hand and wrist, lumbosacral sprain/strain, lumbosacral myofasciitis, and status post arthroscopy of the right knee. The patient's treatment plan included medications to include Tylenol No.3, Celebrex, and omeprazole. An interferential unit was also recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Request for Interferential unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

Decision rationale: The requested interferential unit is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has continued pain complaints that have failed to respond to medications, exercise, and surgical interventions. California Medical Treatment Utilization Schedule does recommend interferential current stimulation as an adjunct therapy to a functional restoration program. The clinical documentation submitted for review does provide evidence that the patient is taking medications and participating in a home exercise program that has failed to resolve the patient's pain and range of motion deficits and would benefit from an adjunct therapy such as interferential current stimulation. However, California Medical Treatment Utilization Schedule recommends the purchase of an interferential unit be based on a 30 day clinical trial that provides objective functional increases. The clinical documentation submitted for review does not provide any evidence that the patient has undergone a 30 day trial of an interferential current stimulation unit. Therefore, the purchase of this unit would not be supported. The request does not specifically identify whether this is for purchase or rental. Therefore, the requested interferential unit is not medically necessary or appropriate.

Request for 18 pairs of electrodes: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS). Page(s): 118.

Decision rationale: The requested 18 pairs of electrodes are not medically necessary or appropriate. The clinical documentation submitted for review does not provide evidence that the patient has undergone a 30 days clinical trial of an interferential unit to support the purchase of the durable medical equipment. Therefore, the associated supplies would also not be supported. As such, the requested 18 pairs of electrodes are not medically necessary or appropriate.

Celebrex 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60 and 67.

Decision rationale: The requested Celebrex 100 mg #60 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has continued stiffness and pain in multiple body parts. California Medical Treatment Utilization Schedule recommends continued use of medications in the management of patients chronic pain be supported by a quantitative assessment of pain relief and documentation of functional benefit. The clinical documentation submitted for review does not provide a

quantitative assessment of pain relief related to medications or documentation of functional benefit. Therefore, continued use would not be indicated. As such, the requested Celebrex 100 mg #60 is not medically necessary or appropriate.