

Case Number:	CM13-0047128		
Date Assigned:	12/27/2013	Date of Injury:	10/25/2012
Decision Date:	03/20/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	11/04/2013

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 & Rehabilitation, and is licensed to practice in Illinois. 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 31-year-old female who reported an injury on 10/24/2012, due to a motor vehicle accident that reportedly caused injury to the patient's neck and left shoulder. Previous treatments have included medications, physical therapy, and acupuncture. The patient underwent an MRI of the left shoulder in 04/2013 that did not provide any evidence of internal derangement; however, did note acromioclavicular joint arthropathy. The patient underwent an electrodiagnostic study that did not reveal any evidence of abnormalities. The patient's most recent clinical exam findings included tenderness to palpation of the cervical and lumbar musculature, and decreased range of motion of the left shoulder with weakness and pain. The patient's diagnoses included internal derangement of the left shoulder, lumbar disc herniation, cervical disc herniation, and anxiety. The patient's treatment plan included continuation of medications, a muscle stimulator unit, and a hot/cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Muscle stimulator unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Stim Unit Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114.

Decision rationale: The requested muscle stimulator unit is not medically necessary or appropriate. The MTUS Guidelines recommend a TENS unit as an adjunct therapy to active therapy. The clinical documentation submitted for review does not provide any evidence that the employee is currently participating in any active therapy to include physical therapy or a home exercise program that would benefit from the support of a TENS unit. Additionally, the patient's most recent clinical documentation does not provide an objective assessment to support deficits that would benefit from this type of therapy. As such, the requested muscle stimulator unit is not medically necessary or appropriate.

Hot & Cold therapy unit for home use for left shoulder, cervical and lumbar 5-6 month rental: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177-179, 303-306. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Continuous Flow Cryotherapy.

Decision rationale: The requested hot/cold therapy unit for home use for the left shoulder, cervical spine, and lumbar spine for a 5 to 6 month rental is not medically necessary or appropriate. The ACOEM Guidelines recommend the application of hot and cold packs as an appropriate intervention for cervical and lumbar spine pain. Additionally, Official Disability Guidelines do not support the use of continuous-flow cryotherapy in the absence of surgical intervention. Even then, it is only recommended for up to 7 days. Therefore, the need for a hot/cold therapy unit for a 5 to 6 month rental is not clearly indicated within the documentation. Additionally, there are no objective findings within the most recent submitted documentation to support the need for this treatment modality. As such, the requested hot/cold therapy unit for home use for left shoulder, cervical, and lumbar 5 to 6 month rental is not medically necessary or appropriate.