

Case Number:	CM13-0060277		
Date Assigned:	12/30/2013	Date of Injury:	08/15/2011
Decision Date:	04/03/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	12/02/2013

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, Pulmonary Diseases, 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 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 54-year-old female that reported an injury on 08/15/2011 while pushing a large rack filled with plates and the rack began to slide away from her. To prevent the rack from sliding, she forcefully pulled it towards her and she experienced an onset of sharp abdominal pain along with pain in her neck, back and both shoulders. The clinical note dated 10/17/2013 indicated the patient's abdomen was tender to palpation and cervical spine and thoracic spine were tender to palpation with spasm. The diagnoses included cervical musculoligamentous sprain/strain with radiculitis, rule out cervical spine discogenic disease, thoracic muscular sprain/strain, lumbar musculoligamentous sprain/strain with radiculitis rule out discogenic disease, rule out umbilical hernia, bilateral shoulder strain/sprain, impingement syndrome, left shoulder adhesive capsulitis, and sleep disturbance secondary to pain. The patient was noted to have decreased range of motion of the left shoulder with positive impingement tests of the left shoulder. Motor strength was decreased at 4/5 and sensation was decreased in the left anterolateral shoulder and arm, lateral forearm/hand and right anterolateral thigh and anterior knee and medial leg. Evaluation of the right shoulder was not able to be performed. Prescriptions were given for naproxen, tramadol, temazepam, tizandinh. Physical therapy evaluation ordered.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of a interferential unit for both shoulders, neck/upper and lower back, as outpatient between 10/28/13 and 12/12/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): Table 2, Summary of Recommendations, Shoulder disorders; Table 2, Summary of Recommendations, Low Back disorders; Table 2, Summary of Recommendations, Cervical and Thoracic Spine disorders.

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

Decision rationale: The request for the interferential unit for both shoulders, neck/upper back and lower back is non-certified. The CA MTUS states that the interferential unit is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The criteria for its use includes documentation of pain medications not being effective in managing the patient's pain or the patient has been unresponsive to conservative measures. The medical records provided failed to indicate prior conservative care has failed and did not indicate medications were not effective to meet guideline criteria. Also, the length of time the unit is being requested for exceeds guideline recommendation of a one month trial to determine efficacy. Therefore the request is non-certified.

Cold therapy kit for both shoulders, neck/upper and lower back, as outpatient between 10/28/13 and 12/12/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): Table 2, Summary of Recommendations, Shoulder disorders; Table 2, Summary of Recommendations, Low Back disorders; Table 2, Summary of Recommendations, Cervical and Thoracic Spine disorders.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 201-205; 173; 298.

Decision rationale: The request for the cold therapy for both shoulders, neck/upper back and lower back is non-certified. The CA MTUS/ACOEM Guidelines state at home application of cold therapy is recommended during the first few days of an acute complaint and heat thereafter. The request as submitted failed to indicate what was included in the cold therapy kit and failed to indicate that at home application of cold therapy was not effective in addressing his symptoms. Therefore the request is non-certified.