

Case Number:	CM13-0061831		
Date Assigned:	12/30/2013	Date of Injury:	02/19/2008
Decision Date:	05/21/2014	UR Denial Date:	11/14/2013
Priority:	Standard	Application Received:	12/05/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine 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 expert 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:

According to the records made available for review, this is a 48-year-old female with a 2/19/08 date of injury. At the time of request for authorization for Bone Stimulator, IF Unit, and Consult with [REDACTED] for Detox from Narcotics, there is documentation of subjective (headaches , neck pain and upper back pain with reduced range of motion and painful movement, and constant shoulder and elbow pain with reduced range of motion and painful movement) and objective (tenderness over the cervical spine, right upper trapezius, right rhomboid and paracervical spine, pain with cervical range of motion, tenderness over the medial epicondyle of the bilateral elbows, and decreased sensation over the right thumb, index, and middle fingers) findings, current diagnoses (cervical degenerative disc disease, status post multiple anterior cervical discectomy and fusion with the last one in December 2012, right elbow ulnar tunnel syndrome, left elbow pain, and bilateral carpal tunnel syndrome), and treatment to date (physical therapy and opioids since at least 2010).

IMR ISSUES, DECISIONS AND RATIONALES

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

AN INFERENTIAL UNIT (30 DAY RENTAL): 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): 118-120.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identify that interferential current stimulation is not recommended as an isolated intervention, except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Within the medical information available for review, there is documentation of diagnoses of cervical degenerative disc disease, status post multiple anterior cervical discectomy and fusion, right elbow ulnar tunnel syndrome, left elbow pain, and bilateral carpal tunnel syndrome. However, there is no documentation that that the IF unit will be used in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Therefore, based on guidelines and a review of the evidence, the request for an IF unit is not medically necessary.

A CONSULTATION WITH [REDACTED] FOR DETOXIFICATION FROM NARCOTICS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Detoxification Page(s): 76.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of a condition/diagnosis for which detoxification is indicated (such as: Intolerable side effects; Lack of response; Aberrant drug behaviors as related to abuse and dependence; Refractory comorbid psychiatric illness; or Lack of functional improvement), as criteria necessary to support the medical necessity of detoxification. Within the medical information available for review, there is no documentation of a condition/diagnosis for which detoxification is indicated. In addition, there is no documentation of a rationale identifying the medical necessity of the requested Consult. Therefore, based on guidelines and a review of the evidence, the request for Consult with [REDACTED] for Detox from Narcotics is not medically necessary.