

Case Number:	CM13-0061864		
Date Assigned:	12/30/2013	Date of Injury:	05/16/2012
Decision Date:	04/11/2014	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 Family 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 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:

The patient is a 36-year-old female who reported an injury on 05/16/2012. The injury was noted to have occurred when 4 boxes of shower gel landed on her face. She was diagnosed with cervical myalgia, pain in shoulder, and pain in hand. Her symptoms are noted to include low back pain. Her objective findings are noted to include decreased right grip strength, a slow gait, and positive trigger points in the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE ELECTRODES (18 PAIRS) PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 118-120.

Decision rationale: As the request for an interferential unit purchase was not supported, the request for retrospective purchase of 18 pairs of electrodes is also not supported.

RETROSPECTIVE LUMBAR SACRAL OTHOSIS BRACE PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12, page 300

Decision rationale: According to ACOEM Guidelines, lumbar supports have not been shown to have any lasting benefit beyond the use phase of symptom relief. The clinical information submitted for review indicates the patient has low back pain and positive trigger points upon physical examination; however, as lumbar supports are not recommended by the evidence-based guidelines for chronic pain, therefore the request is not medically necessary.

RETROSPECTIVE MOTORIZED COLD THERAPY UNIT PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & leg, Continuous-flow cryotherapy

Decision rationale: According to Official Disability Guidelines, continuous-flow cryotherapy is only recommended as an option after surgery for up to 7 days. The clinical information submitted for review failed to provide details regarding the request for a motorized cold therapy unit. As the patient was not shown to have had recent surgery to warrant use of a continuous-flow cryotherapy unit and as therapy is only recommended for up to 7 days, the purchase of a motorized cold therapy unit is not medically necessary by evidence-based guidelines.

RETROSPECTIVE INTERFERENTIAL UNIT PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 118-120.

Decision rationale: According to California MTUS Guidelines, an interferential stimulation unit is not recommended as an isolated intervention, but may be recommended if used in conjunction with recommended treatments including return to work, exercise, medications, and when there is limited evidence of improvement on those treatments alone. The clinical information submitted for review failed to provide details regarding the patient's purchase of an interferential unit. Therefore, it is unknown whether the unit was to be used in conjunction with exercise, medications, and return to work as required by the guidelines. Additionally, a clinical note dated 03/21/2013 indicated the patient's treatment plan included an H-wave stimulation rental for 6 months. A follow-up note dated 04/08/2013 indicated that she was receiving benefit

with use of an H-wave device. As the documentation indicates the patient was utilizing H-wave unit with benefit, it is unclear why she required an interferential unit purchase. For the reasons noted above, the request is not medically necessary.