MAXIMUS Federal Services

Case Number:	CM13-0070760		
Date Assigned:	01/08/2014	Date of Injury:	09/30/2010
Decision Date:	04/29/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/26/2013

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 Internal Medicine has a subspecialty in 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 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 31-year-old female who reported an injury on 09/30/2010 after a fall causing a twisting injury to the patient's ankle. The patient had complaints of wrist pain, ankle pain, and low back pain. The patient underwent an electrodiagnostic study that concluded the patient had severe right sided carpal tunnel syndrome and mild to moderate left sided carpal tunnel syndrome. The patient's most recent clinical evaluation documented that the patient had cervical spine pain and bilateral wrist pain, decreased range of motion, numbness, and weakness. The patient's diagnoses included sprain/strain of the cervical spine, sprain/strain of the lumbar spine, and bilateral carpal tunnel syndrome. The patient's treatment plan included referral to an orthopedic surgeon and wrist splinting bilaterally. A request was made for a multi-stimulator unit and a hot and cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multi Stim Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CA MTUS, Neuromuscular Electrical Stimulation Unit (NMES Devices)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENs Unit Page(s): 111.

Decision rationale: The requested multi-stimulator unit is not medically necessary or appropriate. The clinical documentation submitted for review does not provide any evidence that the patient has undergone a trial of a TENS unit. The California Medical Treatment Utilization Schedule recommends a TENS unit and other types of electrical stimulation units as an adjunct therapy to an active functional restoration program. The clinical documentation submitted for review does not provide any evidence that the patient is participating in an active therapy program that would benefit from an adjunct therapy of an electro-stimulation unit. Additionally, the California Medical Treatment Utilization Schedule recommends a 30 day trial with evidence of objective functional improvement and symptom relief to support the continued use of an electric stimulator unit. The clinical documentation does not provide any evidence that the patient has had a 30 day trial of this type of treatment. Also, the request as it is written does not clearly define the components of the requested unit. As there are many types of electric stimulator units that are not supported by guideline recommendations, the appropriateness of the request cannot be determined. As such, the requested multi-stim unit is not medically necessary or appropriate.

Hot/Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Home Applications of Heat/Cold Packs

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273.

Decision rationale: The requested hot and cold therapy unit is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends the application of hot and cold packs to assist with pain relief and inflammation control. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to the recommended treatment of heat and cold pack applications. There is no documentation to support the need for a mechanical unit. The clinical documentation does not provide any exceptional factors to support extending treatment beyond guideline recommendations. As such, the requested hot and cold therapy unit is not medically necessary or appropriate.