

Case Number:	CM14-0120596		
Date Assigned:	08/06/2014	Date of Injury:	04/13/2011
Decision Date:	10/03/2014	UR Denial Date:	07/16/2014
Priority:	Standard	Application Received:	07/30/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to 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 injured worker is a 56 year old male who reported an injury to his neck, shoulders, and right wrist as well as the right knee. The clinical note dated 06/12/14 indicates the injured worker having been recommended to return work with modified duties. The note indicates the injured worker utilizing Tramadol as well as topical creams for ongoing pain relief. The note indicates the injured worker having demonstrated a 25% decrease in range of motion throughout the cervical region. Grip strength deficits are identified on the right. Minimal tenderness identified throughout the right wrist. The note indicates the injured worker having previously undergone a meniscectomy and chondroplasty at the right knee. The injured worker has also undergone an arthroscopic decompression and partial claviclectomy on the left. The utilization review dated 07/15/14 resulted in non-certifications for the continued use of a TENS unit as insufficient information had been submitted confirming the medical necessity for the device.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS supplies for 3 months (bilateral knee & shoulder): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: No information had been submitted regarding the injured worker's approval for a TENS unit. Additionally, it is unclear that the injured worker has previously undergone a trial of TENS unit, as no information had been submitted regarding the injured worker's response to the treatment. Given these factors, this request is not indicated as medically necessary.

Conductive garment (bilateral knee & shoulder): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 329-360. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg, (updated 6/5/14) Heat/Cold

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: No information had been submitted regarding the injured worker's approval for a conductive garment. Additionally, it is unclear that the injured worker has previously undergone a trial of TENS unit, as no information had been submitted regarding the injured worker's response to the treatment. Given these factors, this request is not indicated as medically necessary.

■■■■■ heating system (bilateral knee & shoulder): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg, Shoulder, thermotherapy, heat, cold

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Heat

Decision rationale: The use of heat is indicated at the knees and shoulder provided the injured worker meets specific criteria to modalities are being utilized in a formal therapeutic setting. No information was submitted regarding the injured worker's ongoing therapeutic treatments. Therefore, the use of local at home application of heat is recommended over commercial products as no high quality studies have been published and very little literature supporting the injured worker response would be more advantageous with the use of commercial products. Therefore, this request is not indicated as medically necessary.

■■■■■ stimulator unit (bilateral knee & shoulder): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-252.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Electrical stimulators (E-stim).

Decision rationale: The use of electrical stimulation at the knees and shoulders is not fully supported as no high quality studies have been published and very few literature supporting the use of this modality at the knees and shoulders. Therefore, this request is not indicated.