

Case Number:	CM14-0139995		
Date Assigned:	09/08/2014	Date of Injury:	06/30/2014
Decision Date:	10/22/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	08/28/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 41-year-old female was reportedly injured on 06/03/2014. No recent progress notes were submitted for review; therefore, the utilization review, dated 8/19/2014, was utilized. There were ongoing complaints of right upper extremity pain. No treatment notes from 6/30-8/19 2014 have been submitted for review. There was no documentation of physical exam findings on the utilization review dated 8/19/2014. No recent diagnostic studies have been submitted for review. Previous treatment modalities were not documented. Request had been made for Pro-tech Multi-Stim transcutaneous electrical nerve stimulation (TENS) unit, electrical muscle stimulators (EMS) Neuromuscular Stimulator Features 30 Day Trial, Optimum Home Rehabilitation Kit and Solar Care Far Infrared Heater (FIR) Heating System and was not certified in the pre-authorization process on 08/19/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Solar care FIR heating system purchase: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back-Lumbar and Thoracic, Acute and Chronic, Infrared Heating System, Updated 8/27/2014

Decision rationale: ODG guidelines do not recommend infrared therapy over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute low back pain but only if used as an adjunct to a program of evidence-based conservative care. After review of the medical records provided, there is insufficient documentation to necessitate the use of this durable medical equipment. Therefore, this request is deemed not medically necessary.

Pro-tech multi-stim TENS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117 of 127.

Decision rationale: MTUS treatment guidelines recommends against using a TENS unit as a primary treatment modality and indicates that a one-month trial must be documented prior to purchase of the unit. Based on the clinical documentation provided, physical therapy and a TENS unit are helping significantly; however, there is no documentation of a full one-month trial. The MTUS requires that an appropriate one-month trial should include documentation of how often the unit was used, the outcomes in terms of pain relief/reduction and improvement in function. Review of the available medical record fails to document a required one-month TENS trial. As such, this request is not considered medically necessary.

EMS neuromuscular stimulator features 30 day trial: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121 of 127.

Decision rationale: According to the California Chronic Pain Medical Treatment Guidelines, devices such as LINT and other neuromuscular electrical stimulation devices are not recommended except as part of a rehabilitation program following a stroke. There is no evidence to support its use in chronic pain. As such, this request for localized intense neurostimulation therapy for the upper extremities is not medically necessary.

Optimum home rehab kit: Upheld

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

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, Acute and Chronic, Exercise Equipment, Updated 10/7/2014

Decision rationale: ODG guidelines recommend durable medical equipment to include (home rehabilitation kit), if there is a medical need, and if the device or system meets Medicare's definition of durable medical equipment listed below. It must withstand repeated use, is primarily and customarily used to serving medical purpose, is useful to a person in the absence of illness or injury and is appropriate for use in a patient's home. After review of the medical records provided, there is no documentation of what the treating physician was requesting to include into the home rehabilitation kit. Therefore, this request is deemed not medically necessary.