

Case Number:	CM14-0176396		
Date Assigned:	10/29/2014	Date of Injury:	04/21/2014
Decision Date:	12/05/2014	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/24/2014

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 & Rehabilitation, has a subspecialty in Pain 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:

This is a patient with a date of injury of April 21, 2014. A utilization review determination dated September 30, 2014 recommends noncertification for an interferential unit and electro shock wave therapy. A utilization review determination dated October 13, 2014 recommends modification of the requested interferential unit to allow for a 30 day trial. A progress report dated September 25, 2014 identifies subjective complaints of dull pain in the left wrist. Medications only help to control the pain temporarily. The patient also has pain in the left thumb. Physical examination findings revealed tenderness around the left wrist and left thumb. Diagnoses include left wrist carpal tunnel syndrome and left thumb de Quervain's. The treatment plan recommends NSAID medication, interferential unit, EMG/NCV, and follow-up in 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electro shock wave therapy x 3 sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Electro shock wave therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical

Evidence: Anthem Medical Policy # SURG.00045 Extracorporeal Shock Wave Therapy for Orthopedic Conditions

Decision rationale: Regarding the request for Electro shock wave therapy for the wrist/thumb, California MTUS does not address the issue. ODG does not address the issue for the wrists. Anthem medical policy notes that Electro shock wave therapy for the treatment of musculoskeletal conditions is considered investigational and not medically necessary. In light of the above issues, the currently requested Electro shock wave therapy for the wrist is not medically necessary.

Interferential until purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120 of 127.

Decision rationale: Regarding the request for interferential unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested interferential unit is not medically necessary.