

Case Number:	CM14-0023355		
Date Assigned:	06/11/2014	Date of Injury:	07/05/2013
Decision Date:	07/15/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	02/24/2014

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 and is licensed to practice in Illinois. 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 57 year old female who reported an injury on 07/05/2013 of unknown mechanism of injury. The chart notes dated 05/25/2014 indicate the injured worker had a history of neck pain with burn to the left arm, also with migraines and headaches. Diagnosis include left rotator cuff tear, cervical spine disc bulge, right shoulder sprain/strain, cervical spine radiculitis, lumbar spine radiculitis and lumbar spine myofascitis. Physical examination reveals cervical spine with tenderness at the C4 through C7, positive Spurling's test bilaterally. Pain with range of motion to cervical spine and left shoulder. Left shoulder reveals a positive impingement test, 2 plus tenderness over bicipital and deltoid muscle, gross muscle strength 3/5 on left shoulder. Left hand and wrist reveal a positive Tinel's test, abnormal two-point discrimination over medial nerve and a positive cubital tunnel on the left. Lumbar spine reveals a slow and careful gait, 3 plus tenderness to the par lumbar muscle pain noted at a 3 plus from L3-S1, straight leg positive at 70 degrees, kemps test was positive bilaterally and 3 plus pain noted to flexion and extension with no pain scale given. The treatment plan includes continuing medications of Neurontin, Fexmid, Naprosyn, Vicodin at night, some and Wellbutrin, repeat physical therapy. The authorization form dated 07/22/2014 was provided in the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

X FORCE STIMULATOR UNIT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Stimulation Page(s): 120.

Decision rationale: The request for x force stimulator is not medically necessary. The California MTUS Guidelines indicate use of stimulators may be appropriate for the following conditions, if it is documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine. Documentation that pain is ineffectively controlled due to ineffectiveness of medications, pain is not effective due to side of medications, history of substance abuse, significant pain for post-operative condition limits the ability to perform an exercise program of physical therapy or the injured worker is unresponsive to conservative measurements. If the above criteria are met then a one month trial may be appropriate to permit the physician or physical medicine provider to study the effects and benefits. Should there be evidence of increased functional improvement, pain and medication reduction. The documentation provided did not address that the current medication regimen was not effective in managing the injured workers pain. Documentation also indicates that the injured worker completed 12 sessions of physical therapy and requesting more physical therapy. As such, the request for x force stimulator is not medically necessary.

SOLAR CARE FIR HEAT SYSTEM: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The request for solar care Fir heat system is not medically necessary. The solar care fir heat system is an accessory to the X factor stimulator that was not medically necessary. Therefore, the solar care fir heating system is not medically necessary.